STATE OF CALIFORNIA

MANAGED HEALTH CARE IMPROVEMENT TASK FORCE

BUSINESS MEETING

Saturday, November 22, 1997
8:00 A.M.
1201 K Street
Sacramento, California

REPORTED BY:
Stacey Wishner,
CSR 11538
Our File No. 41050

APPEARANCES:

TASK FORCE MEMBERS:

MR. ALAIN ENTHOVEN, PhD, Chairman

MR. CLARK KERR

MR. PHILIP ROMERO

MR. HATTIE SKUBIK

MS. ALICE SINGH

MR. BERNARD ALPERT

MR. RODNEY ARMSTEAD

MS. REBECCA BOWNE

MS. BARBARA DECKER

MS. NANCY FARBER

MS. JEANNE FINBERG

HON. MARTIN GALLEGOS

MR. BRADLEY GILBERT

MS. DIANE GRIFFITHS

MR. TERRY HARTSHORN

MR. MARK HIEPLER

MR. MICHAEL KARPF

MR. PETER LEE

MR. J.D. NORTHWAY

MS. MARYANN O'SULLIVAN

MR. JOHN PEREZ

MR. JOHN RAMEY

MR. ANTHONY RODGERS

MS. RODRIGUEZ-TRIAS

MS. ELLEN SEVERONI

APPEARANCES (Continued):

MR. BRUCE SPURLOCK
MR. RONALD WILLIAMS
MR. ALLEN ZAREMBERG
MR. STEVEN ZATKIN
MS. MARJORIE BERTE
MR. MICHAEL SHAPIRO
MR. DAVID WERDEGAR

STANFORD STAFF:

MS. SARA SINGER
MS. CAROL HORHAUS

MR. ENTHOVEN: I want to especially thank you all for giving up this Saturday. Since I expect I'm going to be in a position defending this report, I would be grateful if people would be kind of sensitive to avoiding the stuff that's obviously politically correct. I did read the president's thing or the -- one of the things they said emphatically was that woman should have a choice of appropriate specialists. No reference to children having an appropriate specialist, no reference to men having an appropriate choice of specialists, no reference to grumpy old men having a choice of specialists. And I just think that, you know, one of the things I'm conscious of anyway is just trying to avoid, you know, obvious flights that can be ridiculed by people.

Something happened at the last minute when we were talking about provider incentives and then a very nice nurse appeared and said that she thought nurses ought to be included in that; so there was a vote -- after all, who cannot like a nurse especially if they've been cared for by nurses?

I'm just wondering if people would agree -- then somebody said at another time, "Well, it's like the appropriate health professionals," and I'm just wondering if we -- in other purposes we've developed some language about appropriate health professionals, and in some cases, practicing within the scope of their license or something.

I'm just wondering if people would agree that in some of those cases -- and part of what I'm thinking of if we say "nurses," then the podiatrists are going to come and then the dieticians are going to come and say --

MR. RODGERS: Watch out for those chiropractors.

DR. ENTHOVEN: I was going to get to those. I wanted to come in with a few examples first just so you wouldn't think I was picking on chiropractors. Without objection what I'd like to instruct the staff is that we be able to use kind of generic language in cases like that and other appropriate health professionals, or if it's an issue, their qualifications of their appropriate credentials, health professionals, something like that.

Yes?

DR. SPURLOCK: I absolutely agree. The only concern I have is that in some areas you can't do a global finder in place because in some areas, you have to have a physician's license do certain things or physicians are the only ones capitated; so I think that the almost global finder in place, in certain areas, is not appropriate.

DR. ENTHOVEN: Okay. Well, I detected a generally cheerful mood because we really got through quite a bit of stuff and I think we demonstrated and moved forward; so we'll begin this morning by asking

Mr. Lawrence on the Task Force staff to call roll.

MR. AHN: Good morning. Please indicate your appearance by saying "Here."

Alpert?

DR. ALPERT: Here.

MR. AHN: Armstead?

DR. ARMSTEAD: Here.

MR. AHN: Bowne?

MS. BOWNE: Here.

MR. AHN: Conom?

(No response.)

MR. AHN: Decker?

MS. DECKER: Here.

MR. AHN: Enthoven?

DR. ENTHOVEN: Here.

MR. AHN: Farber?

MS. FARBER: Here.

MR. AHN: Finberg?

MS. FINBERG: Here.

MR. AHN: Gallegos?

HON. GALLEGOS: Here.

MR. AHN: Gilbert?

DR. GILBERT: Here.

MR. AHN: Griffiths?

(No response.)

Hartshorn?

MR. HARTSHORN: Here.

MR. AHN: Hauck?

(No response.)

Hiepler?

(No response.)

Karpf?

DR. KARPF: Here.

MR. AHN: Lee?

MR. LEE: Here.

MR. AHN: Northway?

DR. NORTHWAY: Here

MR. AHN: O'Sullivan?

MS. O'SULLIVAN: Here.

MR. AHN: Perez?

(No response.)

Ramey?

MR. RAMEY: Here.

MR. AHN: Rogers?

MR. RODGERS: Go Bruins.

MR. AHN: Rodriguez-Trias?

DR. RODRIGUEZ-TRIAS: Here.

MR. AHN: Severoni?

MS. SEVERONI: Here

MR. AHN: Spurlock?

DR. SPURLOCK: Here.

MR. AHN: Tirapelle?

(No response.)

Williams?

MR. WILLIAMS: Here.

MR. AHN: Zaremberg?

MR. ZAREMBERG: Here.

MR. AHN: And four ex officios:

Belshe?

(No response.)

Berte?

(No response.)

Knowles?

(No response.)

Shapiro?

MR. SHAPIRO? Here

MR. AHN: Werdegar?

DR. WERDEGAR: Here.

DR. ENTHOVEN: I'm sorry, Les Schlaegel?

MR. AHN:. I'm sorry.

MR. SCHLAEGEL: Here.

DR. ENTHOVEN: Mr. Ahn, please kind of be alert to the fact several of these people who are not here, like John Perez and the others, I do have reason to believe they do intend to be here so as they come in, perhaps you can record when they've arrived.

So to get through our busy agenda today as efficiently and effectively as possible, members will be asked to work through the lunch hour, which means we'll try to take 20 or 25 minutes and we'll just do our eating here. Box lunches were pre-ordered by members and staff and will be delivered. Members will be asked to pay for their lunch upon receipt. So at approximately 12:30 we'll have lunch brought in.

So we're going to start with -- and we'll adjourn no later than 5:00 P.M. We're going to start with old business. These papers were first scheduled for discussion November 21, in some cases even earlier, but due to time constraints we moved them to today. So we're going to take them in our prioritized order: Discussion of Academic Centers and Health Professions Education, Discussion of the Physician-Patient Relationship paper, Discussion of Regulatory Organization paper, and move as quickly as possible into the others: Dispute Resolution of Consumer Involvement, Communication, and Information; Practice of Medicine, New Quality Information, Vulnerable Populations paper, and Integration: A Case Study on Woman.

We will begin with Academic Medical Centers and --

MS. O'SULLIVAN: Dr. Enthoven?

DR. ENTHOVEN: Yes.

MS. O'SULLIVAN: Yesterday I asked if we could move vulnerable populations up to next week and you said we would discuss it this morning.

DR. ENTHOVEN: Oh, that's on today's agenda.

MS. O'SULLIVAN: But it's not very likely -- it's likely we might not get to it today?

DR. ENTHOVEN: No. Maryann, I guarantee we're going to get to it today.

MS. DECKER: Guarantee? Where's the

money? Show me the money.

MR. ENTHOVEN: Now, the 5:00 may slip, but I will -- that's the way I'm encouraging everybody to move right along, but just to show you how concise and brief and timely we academics are, Dr. Karpf is going to begin by the discussion of Academic Centers with Rebecca Bowne; so that's the one on the table. I'm hoping we can complete this in 15 minutes, but our maximum scheduled time in lieu of the good advice I've received from the people who have done this paper is 30 minutes.

Barbara Decker is going to serve as time keeper and remind us of the passage of time.

DR. KARPF: We've had a lot of interesting discussion about this paper, and I would feel comfortable putting this paper forth with two changes, one very minor and one a little more substantive. The minor change relates to the first page where it lists the hospitals associated with Academic Medical Centers. Rather than saying "study," it will say this is a list of them because we haven't studied them in detail.

The substantive issue relates to the last paragraph on page 2 under the discussion of Loss of Disproportionate Share, and I've crafted some or Alain and I have looked at some additional language that he will read that really speaks to the point that with Medi-Cal patients being moved into managed care, there has been a substantial migration of patients away from traditional safety net hospitals to community providers

for providers that have not previously taken care of Medi-Cal patients.

That has created a problem for traditional safety net providers in that although Medi-Cal patients do not come with the greatest reimbursement attached to them, there are some reimbursements, and it ends up being departmental reimbursements for many of these safety net providers, and I just wanted that noted in the paper that as Medi-Cal patients leave, traditional safety net providers have a real financial burden and a strain for them and endangers those safety net providers; so I think I'm going to ask Alain to read the language that we've put together and see if that's acceptable. Other than that, we'll certainly be open to comments, but I think we've vigorously analyzed this paper over time and we've come up with what I think we can come up with.

DR. ENTHOVEN: We've cut in the with the second sentence of paragraph No. 5, on the bottom of page 2, Loss of Disproportionate Share of Funds.

"Enrollees may prefer to establish, A, relationship" taking out "enduring" just, you know, because there's no particular reason to say "enduring." Then "Establish, A, relationship with a non-AMC provider or they may choose to receive care at a facility more easily accessible.

The transfer of Medi-Cal recipients to private providers reduces the financial resources of

traditional safety net providers. Also, although recently reversed under the new Balanced Budget Act, the AMC has experienced a loss to Medicare" or -- oh, sorry. Excuse me. No, I go back.

-- "reduces the financial resources of traditional safety net providers. There is a concern. The private providers may enroll the healthiest, leaving the sickest and most costly with the safety net providers," and then it goes on as before.

Would you like to hear that again?

(Members agree.)

DR. ENTHOVEN: Pick up where it says "mainstreaming."

"The transfer of Medi-Cal recipients to private providers reduces the financial resources of traditional safety net providers. There is a concern that private providers may enroll the healthiest, leaving the sickest and the most costly with the safety net providers."

DR. KARPF: That actually has been the observed experience in Orange County and other areas where Medi-Cal managed care has really taken whole.

Bruce?

DR. SPURLOCK: I'm kind of confused. I'm not sure that I understand how hospital providers enroll elements. It seems to me there's a question of choice and if a Medi-Cal recipient has a choice of facilities to where they get their care, they make that choice

rather than enrolling them. So I don't necessarily understand that concept and notion; and I think we really want to support this concept that Medi-Cal enrollees have a choice. I think that's a fundamental principle.

DR. KARPF: I don't intend to speak to the issue of choice of Medi-Cal providers. I think they're certainly entitled to choice. I think it's a recognition that safety net facilities and safety net providers, physicians, and hospitals, as they lose those patients to the resources, get into increasing financial difficulty and there are other vulnerable populations left behind that will suffer.

DR. SPURLOCK: That's a different statement than what Alain said.

MS. BOWNE: I think what Dr. Karpf is getting at is that clearly some of the sickest of our populations have longer term established relationships with the Academic Medical Centers because historically we have offered services wherein tertiary and quaternary that are sometimes unavailable in the community much less reimbursed at a rate that would make them attracted to the non-safety net hospitals, if you will.

So I think what this is suggesting is that those persons are less likely to change when given a choice and that, yes, I would agree with you, Bruce, that we want Medi-Cal to have choices. In fact, right

now sometimes they have more choices than employees have, but I think what this is suggesting is that it's another one of those factors that is chipping away at the base of population to spread risk within the Academic Medical Center. Okay? And I think there is somewhat of a recognition that, and we know this otherwise, that people without an established relationship are freer and more likely to change when given new opportunities to change than those with long-term established chronic diseases.

DR. ENTHOVEN: This is meant to be a kind of neutral, value-free description of what, I think, is a major factor that has gone into the wrestling over the two-plan model.

Tony Rodgers, after Brad Gilbert.

MR. RODGERS: Can I just bring some information to the table on this issue since I'm directly involved in it?

DR. ENTHOVEN: Certainly.

MR. RODGERS: What we're noticing is that we've changed the model of care for the Medi-Cal recipient. We have created a medical home for that Medi-Cal recipient with their primary care physician. That's where the assignment goes. Now, what has happened for the Academic Medical Center is they will have relationships with these traditional providers. They're not privileged in those hospitals and as a consequence, when we assign to the medical home, those

physicians have privileges at other hospitals, and so what the -- what used to be kind of a free-agent relationship where a member can choose a hospital, emergency room, go to a physician, go to a clinic, we are now creating the continuity by creating a medical home.

The question for the Academic Medical Centers are: Are they going to create a mechanism to allow these community and traditional physicians to have access directly into the hospital through privileges?

Now, this has been accomplished elsewhere, but I know the Academic Medical Centers have a real problem with that because of the nature of their model, and what we really have here if you really want to deal with it is a clash of medical models. We're moving towards a primary care medical home. The Academic Medical Centers are tertiary and quaternary centers of excellence.

What we really need to do and this is the real nut of the issue, long term, is restructure the system to recognize the academic excellence, the centers of excellence of the Academic Medical Centers, but not try to create some kind of mandated program for them that they get a certain number but rather recognize what they do and then allow them to contract for the entire system, and that hasn't happened yet because we just haven't moved that far.

DR. GILBERT: If I can just add to Tony's

comment. The thing that I would disagree with is the skimming, which is really the last statement in your statement because, in fact the skimming was much more prevalent under fee for service, where hospitals would take only the OB and not provide a full range of Medi-Cal services; whereas, under the managed care plan, those hospitals have to provide the full range of services.

Tony is exactly right. We assign the physicians and who then pick a hospital affiliation; so the hospitals in this case don't have the ability to theoretically select only healthy patients, and Tony's point about the fact that traditionally Academic Medical Centers have not had community -- not all of them, it varies by center, have not had admitting relationships with community physicians, to me, is the key to this whole thing.

All the first parts of the statement are absolutely true. The fact that patients are moving is eroding the financial base, and I have no trouble with all of that. I just have difficulty with the concept that somehow within the managed care system, these non-AMC centers are somehow pulling out patients because that absolutely doesn't occur, and it occurred in much more in a fee for service

DR. ENTHOVEN: Brad, would you give me some credit for the fact that I edited "skimming" out of the previous statement?

DR. KARPF: And you put "may" in.

DR. ENTHOVEN: Let me propose some friendly minutes to areas that concern safety: AMC's are concerned, that private providers may enroll the healthiest, leaving the sickest to erode.

MS. DECKER: I'd like to interrupt and mention that it's 10 minutes out of the 15.

DR. ENTHOVEN: Thank you. Now we have Peter Lee, then Berte, Werdegar, Severoni, and Williams.

MR. LEE: My comments don't go to this discussion, so if other people have comments, they can go on his, I'll hold mine so we can wrap up the comments on the specifics, but I have other comments on this paper.

MS. FINBERG: I do. I think that there have been some very serious problems with marketing and signing up healthier people in the Medi-Cal program. It's been well documented. I think it has improved, but I don't think that we can deny that it existed. There have been many examples of private plans, commercial plans, signing up healthier people, going door-to-door marketing where the --

MS. BOWNE: Excuse me, but that's been outlined.

MR. RAMEY: That's 20 years ago.

MS. FINBERG: No. I filed a lawsuit two years ago, and it was very well document. It was a plan that was a commercial plan in the Medi-Cal, a two plan

model. The legislation was enacted and became effective at the beginning of this year, outlawing door-to-door market, but that doesn't outlaw all marketing, and there still are some problems. I agree they're much better.

DR. ENTHOVEN: Would you accept my kind of neutered and neutral wording now that AMC's are concerned with private providers may enroll their healthiest?

MS. FINBERG: Well, I'm not an AMC and I'm concerned, so I felt you narrowed it a bit too much.

MS. BOWNE: But this is a paper on AMC.

DR. ENTHOVEN: This is a paper on --the broad heading here concerns that AMC's have related to managed care.

MS. FINBERG: I guess the reason I want it a little bit broader is that you were addressing the issue of effect on the safety net providers in general, which I see as a major issue that actually goes beyond the Academic Medical Centers.

DR. KARPF: That is correct. Some Academic Medical Centers are safety net providers, others aren't, and there may be safety net providers that are not --

DR. ENTHOVEN: You'd like it to say "AMC'S and other safety net providers are concerned"?

MS. FINBERG: Yes.

MR. RODGERS: You are going to address

this in the vulnerable population?

DR. ENTHOVEN: Next, we are going to have Lee, Werdegar, Severoni and Northway.

MR. LEE: I've got two comments, and I apologize. They aren't specific as to where they go, but one is a big overall. It's the charges of Task Forces to report on the effects of managed care of Academic Medical Centers and health professions education, and this is not a politically correct issue but health professions educations is not juxtaposition education. And even within the Academic Medical Centers, many of them have PA programs, pharmacy programs, dental programs, nurse practitioner programs, and the paper, as it stands, is a physician training -- really it's not even physician training -- physician medical center paper, and I think that that needs to be reflected more that health professions education is not just an AMC issue, and that's one observation.

The other is that in terms of the concerns that AMC's have related to managed care is -- one of the concerns that I've observed from -- AMC's may or may not have them, but about health professions education is that in terms of residency programs, there are not many managed care providers that are big in the residency business and that's, I think, a fact. And that's a question of people, I think Kaiser to the exception, in terms of a managed care plan that actually is big in residency program, which is really a key point of how

we're training future doctors.

It may not be a concern to the AMC's, but it should be a concern we have of one of the ways health plans in the industry picks up the weight for training over time is to make sure that they're involved in residency training, and I'm concerned that I don't think that's happening right now.

DR. ENTHOVEN: Michael, do you want to comment on that?

DR. KARPF: There's certainly some concern on access to patients because of managed care. I think if one looked quantitatively at the involvement of managed care organizations and education compared to some other elements, it might be less; but we shied away from making an issue of that because I didn't have a very effective proposal to make on that, and I think we recognized in the paper there's concern of segregation of patients and also an approach to education that in fact appears focused to physicians and other appropriate providers for managed care.

MS. DECKER: 15 minutes have elapsed.

MS. BOWNE: Excuse me, Peter. In response to that. On page 8 in the paper -- by the way, clearly, your first point is well taken. I've raised it several times. This paper, even though it's short now, has at one point 50 or 60 pages, at one point been 2 pages; and there's been quite a bit of controversy over that and so we elected not to address the other health professions,

and I absolutely agree with you that it is a void here, but it was address by staff and then not addressed.

MR. LEE: This goes back to the charge of the legislation is not to report on Academic Medical Centers alone? It's the effect of managed care on medical centers and health professions education?

MR. BOWNE: Right. Addressing your second point, though, on page 8, we do say that the curriculum designed is not focused on managed care and integrated settings nor on team training and cross professional education, and that at one point, one of the versions had recommendations in it to more aggressively seek residency placement in both management care and underserved and rural areas.

However, the reason that none of the managed care other than Kaiser has a residency training program is because they're, for the most part, contracting with networks and so it would only be if the networks took on a residency program; so you see what I mean? They're sort of disconnected, and it need's to happen, but it doesn't happen.

MS. SINGH: Werdegar and then Severoni and Northway.

DR. WERDEGAR: Lee mentioned some of the points I was going to raise about including all health professional training and also although there is something in here, the need for curriculum change that relates professional education to a managed care world.

I was going to add also or at least raise the question of whether some of the major teaching public hospitals should be included in this discussion.

The AMC's -- the university hospitals are closely linked to major teaching public hospitals, that for all practical purposes are Academic Medical Centers, the San Francisco General Hospital, L.A. County, Harbor, and I think if the -- and this often happens if the public is led to believe that the Academic Medical Center is only the university hospital; whereas, for example, at U.C. San Francisco, the San Francisco General Hospital is half of the teaching and research enterprise.

Not to mention those major public teaching hospitals which face into at least some of the same problems that are described here, I think, would be an omission and also would mislead the readers into thinking that the only major teaching hospital for academic teaching centers were the university hospitals.

DR. ENTHOVEN: That probably could be dealt with by adding "at major affiliated institutions, such as San Francisco General and L.A. County."

MR. LEE: In order that we do that, could we also do the additions about other health professions?

DR. ENTHOVEN: Oh, yes. Yeah.

MR. LEE: So when it comes back next time, there be will some work to incorporated in that, "other health professions"?

DR. WERDEGAR : Yeah. I think it speaks to the issue that Alain raised in terms of using that as a generic approach.

MS. BOWNE: No. No. I don't think that it's just generic. I think that there are very specific training programs for pharmacists, for nurses, for nurse practitioners, what have you, and either we're going to agree at this stage that this only addresses physicians and neglected to address the other program or there has to be significant effort put into addressing those other programs. It's not an editorial comment. We've added a lot. You either do it properly or you recognize that you didn't do it.

MR. LEE: I would agree with it. Could we maybe do a straw poll on whether this gets edited?

DR. ENTHOVEN: Let me just explain a little on where we are. There was a reference made in this paper that -- we've had in there a whole explication of the implications of your remarks, which drew one of our members to the wall.

I think in the case of physicians that we focus on them because that is the most salient, the most controversial. It has become clear that specialists have been over produced. The legislature has tried to get the University of California to correct the specialty balance, to have adequate primary care physicians. There's a lot of issues going on there.

I don't know how much in our staff we know

about the impact of managed care on L.A. health professionals on nursing education, pharmacist education. This is not to imply that nursing and pharmacy are not also very important, but I'm not aware of kind of salient public policy issues at the intersection of these two.

Sara, do we --

MS. SINGER: I don't know.

MS. BOWNE: It was addressed earlier in the discussion. I raised it about five times and it was dropped. So my suggestion would be that we recognize that we have not taken the time to address those issues and that those are also health -- health professions issues that could be impacted by managed care.

DR. ENTHOVEN: I'll tell you, and I hate in any way to inhibit things by problems of the amount of staff and time we have, but as it is in recycling these papers, we're going to be under a terrific bind including working over Thanksgiving, and I just doubt that we are in a position to do any kind of original research -- I mean literature research and so forth.

MS. BOWNE: Then, Alain, maybe we should just recognize, in other words, up front recognize that this only addresses one component of the health profession and that happens to be X and so forth.

MR. LEE: I would take that as an important and friendly amendment in terms of in the introduction noting health professions, including the

range of other health professions education and list them as we talked about here. We then have the option to go into those.

DR. WERDEGAR: And perhaps, at minimum, include some reference to nurse practitioner training and physician assistant training.

MR. LEE: Absolutely.

DR. WERDEGAR: About which there is a lot of available and could be, I think, added relatively easily.

DR. ENTHOVEN: Dave, I'll be looking at my fax machine Monday morning for material related to you, and I'll personally be happy to make a digest and put that in, but if it's not in my fax Monday morning --

MS. SINGH: Ms. Severoni, and then Dr. Northway and then Mr. Williams.

MS. SEVERONI: I do have health professions concerns, but it can be resolved as we're agreeing here, I can move forward with that.

The point that I did want to get to was in No. 5, actually the transfer of Medi-Cal patients. I do just have to dig in a little bit here and in using that word, Dr. Gilbert said "the movement of Medi-Cal patients." I can live more with that than the "transfer" because I think it gets back to Bruce's comment about the choice.

In Orange County, I mean, you know how involved I've been with CAL OPTIMA. We ought to assign

higher numbers of people into the UCI system, and when they had an opportunity to choose to opt out, they really began walking out, and I think that means that the Academic Medical Center there happens to know more about why those patients are leaving.

DR. ENTHOVEN: May I just put "movement" instead of "transfer"? I see the point.

Does anybody object to replacing "transfer" with "movement"?

MS. BOWNE: Excuse me, but, Alain, was I hearing that you think the paper ought to have some statement that perhaps AMC'S need to -- I'm not quite sure --

MS. SEVERONI: What I recommended to the leadership at UCI is this that we begin to study why it is that people are disenrolling and that if they're interested in having those people come back in, that that might be a good place to start, and at this point.

The same for CAL OPTIMA, just in terms of why aren't people moving.

MS. BOWNE: Right.

DR. KARPF: I accept "transfer." It's UCI's fault as much as anyone else's fault that they're losing those patients. I accept that.

MS. SINGH: Dr. Northway.

DR. ENTHOVEN: I could make it stronger like "the choice of patients to move," but you accept "movement"?

MS. SEVERONI: I accept "movement."

DR. NORTHWAY: Doctor, before you do that, there are parts of the state in which patients were transferred from safety net providers against the patients will and there was a big stir about it in Fresno and we finally got it redone, but patients were actively -- particularly those patients who didn't sign up, were actively transferred from safety net providers to other providers who had not traditionally been safety net providers; so it's a mixed bag in this regard, and I wouldn't say that everybody is doing this voluntarily.

The other thing that I would just like to add in that sentence, it says that "the Medi-Cal recipients are moved to private hospitals" as though somehow all private hospitals are somehow bad in this regard. We happen to be a private children's hospital that has over 70 percent Medi-Cal, so I wonder if maybe it could be that if "the movement of Medi-Cal recipients from safety net providers to non-safety net hospitals" would be a little more accurate because there are private hospitals in the state of California who do serve as safety net providers and should be -- because we have the same kind of concerns that Mike and the people at the universities have, that patients will be transferred -- excuse me -- will be moved away from the system.

DR. ENTHOVEN: Is there a general support for that idea?

DR. NORTHWAY: Yeah.

DR. ENTHOVEN: So "recipients from traditional safety net."

DR. NORTHWAY: From "traditional safety net providers to non-safety net providers."

MS. DECKER: Mr. Williams and then Ms. Farber and Dr. Rodriguez-Trias.

MS. DECKER: I'd like to interrupt. We're at 25 minutes now.

MR. WILLIAMS: My comments have actually been covered by Tony Rodgers and Ellen Severoni in principle.

I think there's kind of a tone here that I'm just concerned with about kind of blaming the Medi-Cal patients, and I think that we're on the horns of a dilemma between providing that category of consumer with the same kind of choice that you provide other categories of consumers. Now, there's consequences to that and I think Dr. Karpf is appropriately concerned and the group that's worked on this paper is appropriately concerned about that.

There are other parts of the paper that I would like to comment on that speak to the accounting systems and information and a basis, a fact base, to understand what is really going on in the Academic Medical Centers, but I think we do have a very important social policy question about how do we pay for the kind of research and education and teaching that, I think,

all of us want to see?

DR. ENTHOVEN: Did you say you wanted to comment on the lack of accounting systems?

MR. WILLIAMS: Yeah. I'm going to deal with the next -- on the next page there was some references to findings.

DR. ENTHOVEN: All right. Go ahead.

MR. WILLIAMS: I guess one of the things I was struck by was on page 3 in the second paragraph, it talks about mission base accounting systems are not in place, not possible to identify and track revenues and expenses related to education, research, and clinical care. So there's clearly a lot going on within the systems and we clearly have this managed care activity going on outside, and it seems to be focusing on the external dimension of what's going on in managed care without a good fact base as to any organization, I think, ought to have regarding what's on from an internal inspection.

DR. ENTHOVEN: But this -- you just want to call attention to this?

MR. WILLIAMS: Yeah, I'm just calling attention to this.

MS. SINGH: Ms. Farber, then Dr. Rodriquez-Trias and Mr. Rodgers.

MS. FARBER: I just wanted to talk about the last paragraph on page 4. Now, I recognize when I look at this paragraph that it was probably crafted

about as carefully as it could, and I don't mean to upset the applecart, but I think one of the areas of major dissatisfaction and legal activity centers around: What is experimental care and denial of access to clinical trials?

I think that it would be unfortunate if this Task Force didn't address that issue more squarely. I think you have to look at it from the standpoint of what's a clinical trial today is our future tomorrow, in many regards. And that if we don't have clinical trials and they aren't supported by the insurance industry, you're destroying basically the RND function of medicine.

I think you made a really strong statement about the issues around coverage for anything that's investigational. I don't know where to draw the line. Somebody from an Academic Medical Center might be far more skilled than that, but being on the other end of the industry where what's happening at Stanford today, because tomorrow what happens at a community hospital, clearly that needs to happen, and it has to be supported.

DR. KARPF: I very much agree with that, and it is really a critical issue. After a lot of discussion, we ended up not emphasizing that here because I think that will come up in other parts in terms of: What is medical practice? What is medical necessity? And really has to be cogently discussed in

terms of how do we push the envelope of care and how do we make sure we save the best in the world?

I do think Academic Medical Centers do contribute to that, but it became so controversial and got tied up with the issue of clinic research and it's not necessarily clinical research that you're supporting. What you're supporting is the effectiveness evaluation, the development and RND of new modalities; so we backed off from a --

MS. FARBER: I recognized that there was some backing off, and I'm suggesting that we don't back off. I think it hurts patients and it hurts research.

DR. KARPF: But we bring that up elsewhere. We do bring that up elsewhere.

MS. BOWNE: I think that does need to be brought up elsewhere because I will rise to the bating comment here that I think it is absolutely the role of the National Institutes of Health and the pharmaceutical companies and biomedical research to fund research, and only when it gets out into practice is it an insurance role.

DR. ENTHOVEN: Okay. We've Helen Rodriguez-Trias, Tony Rodgers, and Bruce Spurlock, and then we reached our time. If you can get them in promptly because this is a tight deadline we have to deal with and mark, write notes on your thing and send them in. We can't put in the major substantive changes but issues of clarification and so forth we can deal

with; so I'd like to do that and see if I can get agreement that we just move on.

Helen?

DR. RODRIGUEZ-TRIAS: Yeah. I'd just like to see the area on the impact of managed care on education professionals expanded in the conceptual mode. I mean Academic Medical Centers and their affiliated institutions have been really the mainstay of provider education, particularly in the inpatient mode, and that's something that is a cost that has been born, and that's alluded to in paragraph -- or actually said in paragraph -- third paragraph, on page 3, "using clinical revenues generated from hospital and faculty practice to cross-subsidize their teaching and research mission."

I'd like to see some more emphasis on the issues raised by the fact that no one wants to pay for the education of the health professionals, and where are we going to provide that if the service component of the Academic Centers is eroded, what's available, then, for supporting teaching is not there.

DR. ENTHOVEN: Helen, Medi-care pays Academic Health Centers $100 thousand dollars per year per resident and then when it became widely agreed that we were turning too many specialists and there were suggestions that they had to cut back on production specialists, the AMC's said, "We can't stand going without that revenue. We'd lose a lot of money," and so then they worked out a deal with the government that

said in effect, "If you cut back your specialty production 20 percent, we'll phase it down and let you keep part of the money"; so it is being very strongly supported by the public.

I know that sometimes when peers out there -- the either these messages that's not it's being paid for, but the fact that $6 and a half billion of indirect medical education, et cetera, is being paid.

DR. RODRIGUEZ-TRIAS: Well, but I don't know what the quid pro quo is that between the service components; that is, the revenues that come in through actual delivery of services versus that.

DR. ENTHOVEN: Yeah.

DR. RODRIGUEZ-TRIAS: And if I may finish, so I think that's an area of concern for me. I mean you know if you can actually support it, I have no problem.

But the second part of it is that I think what Tony said was very important about the integration of your providers -- your traditional community providers, particularly for people who have been culturally or in other ways kept out of, marginated, from mainstream services. But there's always been a very strong tension, and I don't know that, you know, we addressed it at all between, again, inpatient and outpatient and even in the same institutions the role of the primary care doctor within handling more complex and coordinating, you know, more difficult illnesses and working in collaboration with the specialist or anybody

else, I think that that's an area of care that's really relatively undeveloped and unresolved and where the contradictions are now are somewhat greater because of this desire to integrate more people in the continuum of care.

DR. KARPF: I think as managed care business becomes a bigger part of the book of business fact of Academic Medical Centers, there is a concern, since managed care per se is not -- some people would argue managed care per se is not contributing to education whereas Medi-care is and Medi-Cal may be and as if book of business continues to rise, may become a bigger and bigger problem.

I think the issue with Academic Medical Centers goes back to what Ron Williams was talking about. I think that the mission base accounting, budgeting systems, need to be developed a bit further and the cost of the education needs to be defined. The cost of education is probably much higher than anyone really anticipates. We anticipated it would cost -- we think it would cost us $300 thousand per year per medical student, but we have to prove that; so we shied away from that because there was a bunch disagreement about that.

DR. ENTHOVEN: We have exceeded our maximum allotted time.

MR. HARTSHORN: Alain, I have 30 seconds.

DR. ENTHOVEN: Okay. Could we have 30

seconds from you, Rodgers, and Spurlock each, or else I'll have to take a vote and ask if the Task Force wants to continue discussing it.

MR. HARTSHORN: Just quickly. We did a study in six states of the care provided through our organization, Academic Medical Centers. We took out all the tertiary care so that it was a comparable study in comparing these costs to community hospitals, and it was between 15 and 20 percent higher. So some managed care plans say, "We're already paying for it," not counting the tertiary care that we need and we have to refer patients to.

DR. ENTHOVEN: We did say in the backup paper that managed care does pay more to Academic Medical Centers. I believe that's revived --

DR. KARPF: Yes.

DR. ENTHOVEN: Okay. Mr. Rodgers?

MR. RODGERS: Yes. I just want to ask that as you look at this paper, you have to look at what the market is driving in terms of change versus what you want to drive in policy. We've always driven Academic Medical Centers by financial policy, giving them subsidies, et cetera. If you want to continue that, you're going to have increase subsidy. This requires really Academic Medical Centers to look at the future. They need their own Task Force. They should bring that together, and they should come up with some solutions that make sense for California.

I'll be the "cassandra" of the system. You're going to see Academic Medical Centers fold very soon unless somebody starts to look at this issue and provide some leadership because they're going to have to compete in an open market, and that is what they have not had to do yet.

DR. ENTHOVEN: Tony, where were you when I needed you?

DR. KARPF: We have competed in an open market.

DR. ENTHOVEN: Yes?

DR. SPURLOCK: I want to make three really quick points. I want to pick back up on what Helen said earlier. It's unfortunate that we didn't have a chance to really debate in this body here, this concept of all pared funding. I think it's as significant as many of the topics that we've discussed in here. We never had a recommendation. I think we're probably behind the eight ball now in getting the full information of that debate, but I think it would have been beneficial for the citizens of California, so it's unfortunate.

The second part on that issue about pared funding is the tangent. When I talked with medical groups and IPA's and physician organizations about what's deficient when residents come out of training, it's the kind of quality of education they had in the managed care environment; so that there's a sort of on-the-job learning for the first two to three years,

not necessarily how to practice medicine, but how to practice in the environment that with which we live, and there's huge cost to that, not just to society and to the medical groups, and I think that's a sort of the tradeoff with an all pare funding, that you get the -- the backside of this is that the people are more apt to be able to work in that environment.

And the third point is, going back a little bit, I want to make one comment on No. 5. I think we have to be very careful about enrollees in health plan in Medi-Cal and the default mechanism, which I think can have grave problems with default mechanisms and assignment of patients.

We need to be careful when we talk about disproportionate shares on Academic Medical Centers and the impact. We may want actually to separate out the impact of managed care and the impact of the default mechanism because that's where the tension and controversy exists.

DR. ENTHOVEN: Bruce, may I just take a straw poll on this question?

What Bruce has said, and some others have implied, is that there is a lot of concern about the inappropriateness of the training now that people who are destined to become primary care physicians in managed care settings, the training they get is an intense inpatient experience rather than an ambulatory care and it's not a managed care. So that's your

concern?

Is there support for our putting in here a statement the Task Force is concerned about this problem?

All in favor?

MR. ZATKIN: I have a question, Alain.

DR. ENTHOVEN: Yeah.

MR. ZATKIN: I mean, Michael, is that the case as far as UCLA?

DR. KARPF: No. We have continued to move more and more education into ambulatory settings. There is required family practice, the patients were all of our students. UCI is going to total primary care. That is the view -- that is the bias, to not be the fact.

MS. BOWNE: I also think that when we had our five learned deans here, there were two of them that seemed to indicate that they were more outpatient managed care oriented, while in my perspective, the other three were still in the Ivory Tower.

DR. KARPF: Those guys from Stanford will never change.

DR. SPURLOCK: There's a question about whether there's been a response to the need, and I think there has been a response to the need. The question is has it been enough of a response? Are enough trainees coming out ready to go? Is the road running when they --

MR. ZATKIN: Well, that would be an

appropriate message.

MS. FARBER: They were all prepared to start the private practice. They didn't learn anything about how to survive in the fee for service world; so I don't think that's changed.

DR. ENTHOVEN: Well, I'm interested in just picking this up with a sentence or two, but I'm going to need permission from the Task Force.

DR. RODRIGUEZ-TRIAS: You got it.

DR. ENTHOVEN: Everybody voted in favor.

DR. RODRIGUEZ-TRIAS: But another one, the role of the academic centers, vis-a-vis, the community of physicians, because this is the really problematic thing about the continuing medical education, and I don't mean the formal CME's, but the kind of reenforcing the role in the continuum of care between inpatient and outpatient, so that there's another part of the role of Academic Centers; so it's not about whom it trained internally, but whom it trained externally.

DR. ENTHOVEN: So both the two issues, one is internal -- you know, inpatient setting versus outpatient setting, and the other is managed care versus not managed care?

DR. RODRIGUEZ-TRIAS: And their enrollees versus -- and their students, if you will. I mean Stanford students who go through Stanford Medical School through Stanford residency training programs versus all that community of physicians that are now in managed

care who may have come from many other sources but who somehow have to link in the continuum.

DR. KARPF: Let me deal with the perception people are having that is just not true about most Academic Medical Centers. Everyone assumes Academic Medical Centers do not really take care of the most unusual, strangest kind of patients. In fact, at UCLA, where we are a very high intensity research institution, third highest funding in the country, 50 percent of our patients come from a seven-mile radius of the Westwood campus from Manhattan Beach in the south to Malibu in the North, La Cienega and Fairfax; so we are in fact a provider of primary care and of longitudinal care to a very large number of people. We now have 20 facilities in the community that is primary care focused; so it's not like we haven't paid attention to primary care. It is our biggest book of business, and that is true for most other academic health centers that are in fact competing in the environment.

DR. ENTHOVEN: Thank you very much, Michael. I thank all of you. We didn't beat our component, but we came very close.

Our next paper is on the -- with respect to the procedure for the general public, if we're voting on a paper, then we feel we must listen to them before we vote, since we are not voting on this paper but merely discussing, we will ask the members of the general public to restrain their comments until the end

of the day and then we can consider it at that time.

We are moving on to physician-patient relationship.

MS. BOWNE: Alain, if they're only going to have to take three minutes, I would hate to have to wait someone wait until 5 o'clock at night.

DR. ENTHOVEN: Well, is this the only topic of concern, Ms. Dodd, or are we going to have --

MS. DODD: I clapped when my point got made.

DR. ENTHOVEN: The next paper is on the physician-patient relationship. I want to welcome Mark Hiepler for -- I know that this is a considerable sacrifice for Mark from the point of view of a personal family reunion, but he's very interested in this issue; so thank you, and I hope you've recorded that he's present now.

This is the physician/patient relationship findings and recommendations. We have five pages to discuss. Let's see. Who are our representatives?

Brad Gilbert, do you want to lead us off? By the way, we can try to do this in 30 minutes, but when we get to an hour, Barbara Decker will keep us on track, and I'll try very hard to be brutal, but let's see if we can do it faster.

DR. GILBERT: I'll make some quick, general comments and then I have a specific provision to one section based on comments from a number of

individuals and groups.

In general, the paper has been changed in terms of the body with the firm oppositional information describing the importance in the relationship of the physician-patient relationship -- excuse me -- provider patient relationship, or it's still "physician" in the listing. And in addition, many of the recommendations that were originally presented have now been or are going to appear in other papers; so a number of our recommendations, actually we debated yesterday in the provider incentive section, there are some that have been transferred to practice of medicine; so in some ways the number of recommendations and actually some of the more substantial recommendations will be discussed under different papers.

What I'd like to do now and then, Mark, I'll let you have a chance to make some comments, is if people could turn to page 5 of the paper, I'd like to talk about the issue that came up around advanced practice nurses or nurse practitioners and RN's or clinical nurse specialists, et cetera, and physician assistants. There really was and, Mark, you haven't had a chance to talk, but I'm going to go through some changes.

I want to view different recommendations related to this physician availability piece, which is E, No. 4. The intent of this was if a patient was chosen or specifically assigned to a physician, that if

the health care plan or the medical group somehow directed that individual to someone else, and particularly an advanced practiced or a PA, that we felt, the group felt, that the patient need to be informed of that change. So it was only in the situation the concern was, and I don't know that we know exactly how often this occurs, but there are examples where for some of our members, they specifically choose a doctor, but then they're directed because of the availability of the physician in some cases and other reasons for other cases, to a physician assistant or a nurse practitioner, and we felt there should be some informing of the patient that that shift in who is caring for them had been changed.

In addition, we felt if there was situations, and this is not universal, but there are circumstances where individuals can choose nurse practitioners or physician assistants directly, then of course this would not be an issue.

My recommendation is that we make that more specific in regard to when a physician is specifically chosen or they are specifically assigned and that there be verbal informing of the member if they're directed to a different care giver.

DR. ENTHOVEN: Do you have words then to change that?

DR. GILBERT: The words would be something along the lines of "if a patient is specifically

assigned or chooses a physician as their primary care provider and the health plan or medical group or physician office directs them" -- and that can happen in a number of ways -- "to an advanced practiced, NP or PA, that the patient be informed that they will be seeing a nurse practitioner or PA," verbally informed.

And then the second piece, which I think actually goes out saying, I don't know if anyone has stated it, but if they choose a nurse practitioner, or PA, as their primary care provider, then this is really irrelevant because they have made that choice.

The third piece, which caused much of the letters we got and they were very cogent and an appropriate response to what was, I think, a bit of a mistranslation in the final wording is we had no intention of changing the supervisory laws which exist around the supervision of either nurse practitioners, advanced practice nurses, or physicians assistant, and if you took our -- that recommendation literally on the 20 hours, we would be doing a recommendation that would substantially change the supervisory requirements. And that was not our intent; so we can either just strike that part of it or make a statement that, you know, we're not intending to change the current --

DR. ENTHOVEN: Just strike the whole sentence?

DR. GILBERT: I would strike the sentence. That would be my suggestion.

And then finally there were a number comments made about our choice of language in this section, which I agree with, which is that we should be specific. We're talking about the term "advanced practiced nurses," which includes both nurse practitioners, clinical nurse specialists, and certified nurse mid-wives, that we either list them all or use the term "advanced practiced nurses" and "physician's assistants" rather than "physician extenders," and I would recommend that we be more language specific in our language. I think that's appropriate. So that's the only specific --

DR. ENTHOVEN: Brad, I just put an equation here APN equals PA --

DR. SPURLOCK: No. No. APN equals nurse practitioner, clinical nurse specialist, or certified nurse mid-wife. And then a separate category as "physician assistants."

DR. GILBERT: So we wanted to remove the references to "physician extender" and use those other terms. So those are the specific changes that I would recommend in the discussion and then, Mark, I don't know if either -- we had a chance to talk about that specific issue or if you had other comments?

MR. HIEPLER: I think just to shed a little extra light on a couple areas that seem to get some italics, but with no specificity, if we go from the reverse in the back, page 5, under Financial Incentives,

recommendations related to financial incentives, I read those this morning at about 4:30 and it still seems to be that there is a big issue as to disclosure, who's doing it and what it should state.

I think if we do give our recommendations in just a general variety, we will see the same thing that came about with the previous legislation that talked about if there is an incentive, it should be disclosed, and it's meaningless and it's wording right now, so I have some specific language that we were proposed. Again, I think that if anybody is capitated in a system, it's the plans -- it should be the plans duty to explain those services that are capitated.

I would like to have the specific capitation amounts on the board too. I know there's a lot of dissention on that, but if someone is capitated throughout a system, it should be the medical group or ultimately the IPA'S duty to disclose what is being capitated throughout the system. If it's chiropractic care, if it's speciality care, if it's cardiology care, what it is, because then you know where the play is. It's my premiums dollars, and I have a right to know how someone's being compensated.

So I had some further workouts of that specific language in that disclosure area because we're all talking about disclosure, but I'm never seeing how we're letting it hit the road as to what is being disclosed, how it's disclosed; and if you don't do that,

then I guess there would be a paragraph that shows up somewhere that is meaningless and gets put in the back of something; so I would like to propose that we be a little more specific in the approach in who's disclosing it, and then it may be more meaningful.

DR. ENTHOVEN: Mark, I think that the more detailed thing about the process of disclosure and all that is in the regulatory paper; is that right?

MR. HIEPLER: I've read all of them, and none of really say who should and what should be disclosed, that I could find. I didn't really attack it. I read them. Correct me if I'm wrong.

DR. ENTHOVEN: Well, let's take a look at provider incentives.

MS. FINBERG: It just says the method should be disclosed. It doesn't say who and how.

MR. HIEPLER: I believe it leaves everything else to be determined later.

MS. O'SULLIVAN: Also, in the other paper, it puts the burden on the patient to ask for the information from the provider. I would be very reluctant to ask my doctor how he's getting paid.

MR. HIEPLER: And how can you ask when you don't even know the questions to ask? That's the problem. Because any survey indicates that most of them don't know and everybody believes it's still fee for service.

MS. SINGER: I would just like to clarify

what we talked about last night for people to recall. There is pro active disclosure on part of the health plan of an addition to the general method of payment on the types of financial incentives used. We've also recommended a pilot project for working with the medical groups and other provider groups to determine what is a clear, simple, effective way to disclose the compensation arrangements that they have with the providers of whom they contact, the idea being that it's a complex thing that we are not clear at this point about how to do it in an effective, efficient manner that doesn't get too complex.

MS. BOWNE: Sara, what section is that in?

DR. ENTHOVEN: Provider and incentives paper, page 1 and 2. It states, "Provider groups and health practitioners should be required to disclose the method of compensation and financial incentives they receive upon request of a patient. Provider groups should also be required to disclose the methods of compensation and incentives paid to their subcontractor."

MS. SINGER: Right. That's recommendation No. 3, is the "there is disclosure upon request," but in addition to that, the intention is that through a pilot project, we will be able to work through what is the appropriate disclosure of a medical group.

MR. ROMERO: Mark, does that address your concern?

MR. HIEPLER: I think to the future of specificity, it's fine, but I think it's very easy to say the services and systems even though they're capitated can easily be denoted, and that's a real great step in the right direction to allow people to know here's the new system of payment, good, bad, or indifferent, and in your system everybody is capitated or just your primary care doctor is capitated. That's a real easy step to take. I don't think we need the three-year study as to whether we should allow the patient to know who's capitated or not.

DR. ENTHOVEN: Well, given the way the history of this issue, which has won a badly worded legislation which ends up in something that's -- in a result that has nothing to do with what the legislative intent was, we thought it would be wise to say this time, DOC, conduct a pilot project in which they designate a number of ideas, and medical groups work with them to develop such a statement; then test it out on the -- you do kind of a market test and ask patients: Is it meaningful? Do they understand it? Is it helpful? Do you want to receive this information?

MR. LEE: As a point of order, yesterday we didn't vote on it, we had discussed on it, the next December meeting we're coming back specifically on provider incentives.

Mark wasn't here yesterday, and if has specific language, that we consider voting on at the

next meeting, I think that's going to be appropriate. We had an intent yesterday to discuss this particular topic, and I think we need to move on. I think that having more discussion, we need to have more, but that a proposal on what the vote would be on is -- they're not provider incentive specific.

DR. ENTHOVEN: Okay. With specific wording. You're right. Thank you, Peter.

DR. KARPF: Two language comments and one substantive comment. Under C "information" -- "informing patients of all option," in the first sentence you have "managed care, expects patients to play a more participatory role in their care."

I'm just curios whether you have good information for patients is true, whether you indemnity, managed care, or no insurance. That really doesn't say anything, and I think that really should come out. So where it says, "We have an internalistic the system," we don't have an internalistic system. 20 years as a practitioner with lots of indemnity insurance, I can guarantee you many, many patients take a considerable amount of care for themselves.

DR. ENTHOVEN: This is item C, on page 2?

DR. KARPF: Yes. Just take out that first sentence because I don't think it's true.

MR. LEE: "Patients should be participatory all the time"?

DR. KARPF: Yes. "Patients should be

participatory all the time," not just under managed care.

DR. ENTHOVEN: Is there a general support to that? Can I just see a show of hands? How many people support that?

MS. BOWNE: I'm not sure where it is.

DR. ENTHOVEN: Oh, under C, page 2, item C. I guess it just strikes the first sentence which says, "managed care expects patients to play in more participatory role in their care."

DR. KARPF: All patients should participate in their care.

DR. GILBERT: I would strike the first two sentences.

DR. ENTHOVEN: Okay. I just want to see if there's general support for that. I'm doing a straw poll on striking the first two sentences, page 2, item C, the first two sentences.

14. That's going to be a majority by subtraction. Without objection, I won't take the note. Okay. We'll remove it.

DR. KARPF: The other language, which is under "physician liability," we have "physician extenders often increase access at lower cost and may demonstrate better communication skills than physicians," which may be true, "but made coordinate in an oversight, more difficult." That is not true.

DR. ENTHOVEN: Where are you now?

DR. KARPF: Under E.

MS. FINBERG: Page and section?

DR. KARPF: I'm sorry. Page 3, section E. It's the second from the last sentence and it says, "physician extenders often increase access at lower cost and may demonstrate better communication skills than physicians," some can argue about that, "but may coordinate in an oversight, more difficult." That is not true.

In fact, physician extenders and nurse practitioners are oftentimes, at very much, coordinating link a in our institution.

DR. ENTHOVEN: So it's strike that clause --

DR. KARPF: Don't I get a clap for that one?

DR. ENTHOVEN: So if we strike that clause, then we get to the question.

DR. KARPF: I actually would prefer the whole sentence going out, but I'm not sure that many physicians would agree that nurse practitioners are all better communicators than doctors. Some are and some aren't.

MS. RODRIGUEZ-TRIAS: It says "may demonstrate."

DR. KARPF: Getting down to a more serious issue. On page 4, under C, informing patients of all options under 3-F it says, "require physicians,

facilities, and medical groups to disclose to patients upon request the number of outcomes of prior procedures performed." I'm not sure what "outcomes" means here and that's asking for a lot of information -- potentially a lot of information about a lot of different procedures. Does "outcomes" mean mortality? Does it mean morbidity? Does it mean functional status? And much of that data is not available for every procedure in every hospital; so it's a very broad statement that can't be supported at this point in time by the systems we have.

DR. ENTHOVEN: Dr. Werdegar?

MS. DECKER: I interrupt and say that we passed 15 minutes.

DR. ENTHOVEN: Thank you. Okay. Dr. Werdegar?

DR. WERDEGAR: I don't promise these in the fax machine on Monday.

DR. ENTHOVEN: Let me ask you this first: Can we just stick to Michael's point here about outcomes?

MR. LEE: Alain, I suggest, as we've done, none of the papers are going to helpful that go through recommendation by recommendation, which we'll do if we vote. I've got comments on No. 3, but maybe we'll be able to walk through and if people have comments on No. 1, comments on No. 2.

MS. BOWNE: Comments on No. 1.

MR. LEE: May I suggest that other people

may have comments on pre-one first.

DR. ENTHOVEN: Okay.

DR. WERDEGAR: I want to make some general comments which I think will be applicable perhaps to each of the individual sections. First, I just want today acknowledge, whoever the authors were, how valuable it was that it started with describing a covenantal relationship between patient and provider. I think that was the core introduction, and in fact it's one of the most important parts, that and how we do regulation of managed care. But I think throughout, a theme has been the concern for the covenant relationship people patient and provider is the great concern; so I think that was very beautiful and quite powerful.

I think the recommendations, myself, should all relate to factors that might adversely affect that covenantal relationship or are perceived as possibly negatively affecting that and I think -- or to put it in the positive, to mention the items that preserve that relationship, and I think a number of them have been identified. Continuity, I think was important. I would probably start with B and not emphasize the gatekeeper role, but sort of acknowledge that one of contributions of managed care may be one of its most important contributions, is that it links the patient, maybe one day the family, to a primary care provider and to give emphasis to that.

That is a major contribution and not

emphasis so much the 30 percent of studies medically unnecessary, but I think there, the point that has come up repeatedly with regard to the relationship is that when the primary care physician wants to make a referral, there had been interference, and a denial, and a lot has been said that that should be handled in a different way. There could be utilization review afterwards to see the appropriateness of referrals as the primary care physician should be able to make the referrals without interference.

I think informing patients of all options, that again, the covenantal role is to be able to speak freely to the patient and share information fully, and so the emphasis there should be on issues of gag rule, reprisal, anything that interferes with that ability to speak freely and share freely. I think the stuff at the end of that particular paragraph, "informing patients of all options, while it is true that we need something about assessing and informing patients about experience and competence of their personal physicians and delivery systems, that would not be the place I would put that. I put that elsewhere in quality measurement because here I think the main force of the paragraph is on, instead, the communications ability between primary care physician, or between provider and patient.

I think on financial incentives, and we're going to come back to that and Mark discussed it, but some of the discussion yesterday, particularly that 4-A

and 4-B, that stuff that had to do with placing particularly the primary care physician in an untenable situation might be referred to here.

There is nothing about confidentiality. I was looking at the -- which was distributed yesterday -- the Federal Patients Bill of Rights and there's some nice stuff in there and some good language too, some of it may be applicable in this section on physician-patient relationship. They do mention the importance of respect for confidentiality and communications, and that could be added in here. I think that's another part of the covenant stuff.

DR. ENTHOVEN: All right. Thank you very much, Dave.

I think now we need to move point by point, so if we go to page 4, let's take A and 1, continuity with physicians.

Yes? Martin Gallegos.

HON. GALLEGOS: Thank you, Mr. Chairman.

First off, I'd like to just comment about the title of this section, and I'll assume that this is going to fall in that category where we're going to address this as continuity with providers or with their health care professional because, you know, there are relationships that are set up in the system that aren't just strictly patient-physician. It could be podiatrist. It could be clinical psychologist, and on and on and on, that are equally as important to

providing quality care to the patient.

MS. SINGER: I'm sorry. I need to ask a question about that and get some guidance. The legislation asked us to look at physician-patient relationships, so in this paper what I did was included a paragraph which says that in general many of these issues apply to all providers -- you know, the same language, practicing within their scope of license, but I did not change all the words here to physician-patient relationship. Many of the studies that we considered applied just to physician and many of it, certainly all of the historical discussion and analysis, is just about physicians, and so in this paper I didn't make that change and if we wanted to --

DR. ENTHOVEN: Because the legislature told us to look at -- talk about physician-patient relationship.

MR. ROMERO: In fact, I'll just read the language specifically. It says 1 of the 5 findings we're supposed to develop is the effect of managed care on the patient-physician relationship, if any.

HON. GALLEGOS: If I could just follow up on that. There was subsequent legislation that had been introduced by assembly member Richter that was related to the Task Force. It had to do primarily with economic features, but when that bill came to the Health Committee, it was specifically noted that we wanted to have that wording changed in the bill, and the bill was

passed out of the Health Committee.

Now, it didn't move along the process, never got signed; however, it was clear at that Assembly Health Committee Hearing and the legislature was for the "physician' wording to be stricken and to become "provider" or "health care professional," so I mean -- so just to clarify that it is the intent of the legislature that "physician-patient relationship" be used in the broad sense of "provider."

DR. ENTHOVEN: I don't mean to be legalistic about it. Sara's point is that most of the literature is on this particular relationship, not with other professions as well; so I think --

MS. SINGER: The way I've handled it in the text and I proposed moving this up to the finding section also, I said that "in addition physicians are not the only providers who have a significant relationship with the patient.

The issues discussed in this paper are not exhaustive and may be applied to all appropriately licensed health professionals within their scope of practice." That's now in the body and I can move that up, play with the language a little bit, but I didn't want to change all the words because it would be inaccurate to represent some of the information presented.

DR. ENTHOVEN: We're just trying to obey the law, Martin.

HON. GALLEGOS: Now, a followup to that, Brad, when we were in Southern California and we talked about this issue about physician termination without cause, you know, we talked about, as a group, about the importance of being able to inform the patient that the doctor or the provider's contract had been terminated. We talked about maybe doing some advance notice to the patients, you know, your doctor's contract or your provider's contractor is going to expire in 90 days or 120 days or whatever, and my understanding at that point was that we were going to include that as a firm recommendation to the full Task Force for a vote.

As I see it here in the paper, it's kind of like an add on, "Oh, by the way, yeah, there might be something here," and that to me is not strong enough for what would satisfy me, and I want to mention that to all the Task Force members. I think that's something that's very important, that the continuity of care issue is that patients have adequate knowledge, that their doctors are no longer going to be there so that they just don't call up one day and get told, "Well, sorry we're no longer contracting with that doctor or that group or that provider."

I know you make reference to another paper we haven't dealt with yet, and I don't know if it was dealt in the consumer information paper or not. There's some wording in here that says some recommendations are in the consumer information, communication involvement

paper, but I didn't see it there and I know we haven't gotten to that paper yet.

DR. GILBERT: There were two parts that I think we need to talk about and one is the member noticing, which is what you're discussing. The other was it got fairly convoluted about the issue of termination of physician contracts and we had a specific discussion at the earlier meeting about that there should be a reason and there should be due process, which we talked about that. And then additional research and suggested that in law -- and, Sara, you may need to comment on this -- that for termination there has to be a reason; but non-renewal is still an issue, you know, just not renewing your contract in the next contract period and what should the Task Force do about that? And that's that kind of general italic statement there, but the member noticing issue, I think, kind of fell off.

DR. ENTHOVEN: We could take a straw vote on it. Is the sense of the Task Force that we should put in -- after 1, should be 2 -- without the precise words, "notice to patients of intending non-renewal of provider contract"?

MR. LEE: Or termination. "Non-renewal or termination."

MS. BOWNE: Who would get notified?

DR. ENTHOVEN: The patient under the care of the provider.

MS. BOWNE: Oh, the patients under the care. Because where you get into an issue on this is let's say, the non-renewal is one thing, but let's say the provider is being terminated for malpractice, breach of contract.

DR. ENTHOVEN: But that's cause.

MS. BOWNE: Right. But you don't want to be telling the patient that because then you get into whole defamation and character on the provider.

DR. GILBERT: No. All you're talking about -- if we do this, this is a DHS requirement under Medi-Cal, which is that we must notice the members 30 days in advance of some reason that their physician or their provider is no longer available to them. If we don't give the reason to the member, we simply say --

MR. BOWNE: I was just concerned. I didn't want, as a member, to be getting something in the mail that said --

DR. ENTHOVEN: In that sense, if the Task Force will raise their right hand that there should be -- we'll wordsmith it but -- "notice to patients of impending non-renewal or termination 30 days in advance"?

MR. ZATKIN: Question, Alain.

DR. ENTHOVEN: Yeah.

MR. ZATKIN: I would like to hear from Maureen with respect to the potential impact on health plans generally.

MS. O'HAREN: I think we're already required to do it.

MR. SYPHAX: There's no specific requirement in the statute at this time for any particular time period of notice; however, the department requires notice in order to preserve the statutory requirements that there be continuity of care.

The industry standard informally is approximately 30 days, but the department does not object to the plan and gives them at least that much time.

MR. SHAPIRO: I think there is law on this, which is recent, on the determination, but not on renewal.

DR. ENTHOVEN: This is a concept, not the minutia. So how many favor the concept? Raise your right hand.

MR. RODGERS: Including medical groups and IPA's; right?

DR. ENTHOVEN: Yes. I'm going to declare that's in. Now, the next issue under that is the business about "required to provide a reason for non-renewal of a provider's contract without cause."

That is, of course, a major fundamental change. That's a large issue because that interferes with a right to contract. It's a kind of job protection that doctors don't provide their nurses and it doesn't exist. It's like fundamental to our economy to be able

to contract that will -- not to renew. Honda can't sue me if next time I don't buy another Honda. By just saying that, not to argue the case, but to underline, we are talking about a fairly large issue here. All right.

Spurlock? You want to comment on that?

DR. SPURLOCK: On No. 1 in general, not in the one you just threw out.

MS. DECKER: I'd like to interrupt and say it's been 30 minutes.

DR. ENTHOVEN: Okay. Commenting on that point. Is there a proponent?

Yes. Ron Williams?

MR. WILLIAMS: I'm certainly not a proponent.

MR. LEE: Ron, are you talking about No. 1?

MR. WILLIAMS: I'm speaking to about the non-renewal issue. It would be extremely chilling on the development and formation of networks on the admission of new physicians into networks. I think it would some have, again, unintended consequences and I just think it's a bad idea generally.

DR. ENTHOVEN: Any other comments on that point? Mark?

MR. HIEPLER: I was the one that kind of fought to at least get that italics back in here and the reason was that at our separate hearing, we had physicians and we received all kinds of letters and

we've heard testimony about the concern that the Business and Professions Code retaliation statute is not strong enough and that what happens is often physicians are terminated based on the contract, not for cause, and there is no communication process and then physicians want to just sue the person.

One of our middle level approaches to not change contract law was to say that even in a not-for-cause, and I think Brad agreed in this and said -- and correct me if I'm wrong -- that it's just chicken if you don't give someone an explanation, that in a not-for-cause termination, that the physician should have an opportunity to meet with the people terminating, terminating the contract, not as a formal hearing, but at least there's a basis for explanation.

DR. ENTHOVEN: A basis for lawsuit, Mark?

MR. HIEPLER: No. Not at all because contractually you're not changing the law, but you're allowing communication.

MS. SINGER: We went back and checked the law in Knox-Keene and currently there is a requirement that there must be disclosure for termination during the period of a contract with or without cause and specific explanation with cause.

The only outstanding question is whether or not there should be disclosure upon non-renewal. And currently, as I understand it, there is a working group of industry organizations who are working on some

compromise related to that, but termination during a contract period is no longer an issue. It's got to be disclosed.

MR. HIEPLER: "Disclosed?" What do you mean by "disclosed"? Obviously the guy's been told that he's terminated, but the issue is --

MS. SINGER: The reasons have to be disclosed.

MR. HIEPLER: Except in non-renewal; correct, Sara? That's what you're saying?

MS. SINGER: Yes.

MR. HIEPLER: That's the big area. That's the big area. That's the whole point because that's where we're seeing most of this disjointing of the doctor-patient relationship, is at the non-renewal stage. If a doctor is being abusive or a practitioner is being abusive, sure there's already action that can be taken for cause. I mean that's the law. The non-renewal is the whole issue here, and that's why I think it's important we address it.

DR. ENTHOVEN: Spurlock?

DR. SPURLOCK: Since we're talking about the non-renewal termination issue, I think I said my piece most of it down in upland for most of you who were there. I think there is one thing I kind of want to highlight with that, and there is this sort of fairness issue that people sort of circulate around this whole concept, and it cuts both ways. There is a fairness to

the physician who's been non-renewed. There's also fairness to the physicians that remain in the group or the IPA that had that position about the work ethic and the work environment with which they work.

The long and short of it is this is a legal issue. We have estimates from several folks that it's $50,000 per termination on anybody that goes through the course of a full termination process and, you know, it mucks up the system and it really breaks down to what's happening.

Now, there is a group that was discussed earlier that Sara mentioned that was working very, very vigorously on this and there actually has been some movement towards compromise amongst physician organizations about what is fairness amongst physicians.

I think that's where we need to keep this. If we go into this whole issue, it really will muck up this process, which I think will have a really good intended outcome that we all can live with.

DR. ENTHOVEN: Okay. Mr. Zaremberg?

MR. ZAREMBERG: I'd just like to echo the chairman's remarks that this is a very broad issue that has very significant implications. You're talking about a contract where both parties agree that it would terminate. It's over. And now you're saying once it's over, no, it's not really over. Even though we agreed, there's still a cause of action if we don't give a reason that's adequate.

MR. HIEPLER: No. No cause of action.

(Members talking at once.)

DR. ENTHOVEN: One at a time, please.

MR. HIEPLER: Just give some explanation.

MR. ZAREMBERG: Please explain to me how that applies to every other contract -- that you do, Mark, in your business -- whether you should have to give a reason for everybody when a contract terminates by its own terms. It's over. And then once you give a reason, if that reason is not satisfactory to the individual, why I mean -- why, you know, when you say you're performance wasn't satisfactory, as Dr. Enthoven said, maybe that's a defamation.

It applies in every particular situation where a contract, and I think in your business, and in your business, that you want the government to come in, in law and say you have to give a reason why you didn't renew your lease on your car, on your building, on your employees.

DR. ENTHOVEN: Martin?

HON. GALLEGOS: Alain, it's real simple. We're talking about patients' health here. We're talking about doctor-patient relationship. We're not talking about what contract purchased X amount of pencils. This is a doctor's patient relationship. This is an individual's health care.

MR. ZAREMBERG: I appreciate that and I think we can find a number of situations in real life.

DR. KARPF: Mr. Chairman, can we take a straw vote?

MR. ZAREMBERG: But I think the whole point here is it was over by both parties.

MR. HIEPLER: We're not changing anything and there's no setup in it. What we're actually doing is reducing the furor of physicians who suspect other motives by just asking that a statement be given as to any basis they have other than the contract terminating.

It's not setting up anything. It's actually reducing the furor that we see when physicians come to us and say, "I want to sue the health plan because they never gave me a reason."

MR. ZAREMBERG: You don't have the ability to take a recourse if you find a reason to be not satisfactory. What would be the purpose of giving them the reason? To make the physician feel better? If you don't have a reason -- and I'm concerned that there will be a recourse over a contract that's already -- by agreement then come to its ends.

MR. HIEPLER: You're getting all that you want in the contract not for cause termination, but it's allowing a communication to go through so that the doctor doesn't immediately suspect improper motives. It's doing nothing illegally other than enforcing some communication because many people -- once we've got people to sit down together and discuss it, we no longer have the threat of litigation, and that sets it.

DR. ENTHOVEN: All right. What we're talking about is contracts that made no provision for continuity. We're contracting with you for your -- whatever it is, and does the entity presumably on either side have to give a reason for not renewing their contract?

I'd like a straw vote. How many people feel that the party that chooses not to renew the contract be required to give a reason?

MS. BOWNE: Say it in the positive.

DR. ENTHOVEN: Say it in the positive? Would you say it for me, please, Rebecca?

MS. BOWNE: I'm biased on the issue; so I shouldn't say it.

DR. GILBERT: You keep using the word "termination," and we're not talking about termination.

DR. ENTHOVEN: We're talking about non-renewal.

DR. GILBERT: And the most of the testimony that came to us, the pediatrician from Ventura, where she was terminated mid-contract, and the law already has in it the need for disclosure. I don't know that there's due process behind that law, which may be an issue. We're talking about when a contract ends because that was the contract originally agreed to between the two entities.

DR. KARPF: Mr. Chairman, you asked for a vote?

DR. ENTHOVEN: Is it clearly understood? Which way are we voting? We're saying if we raise our right hand that we're for this if we say the that contracting parties must provide an explanation if they choose not to renew the contract.

All in favor of requiring that raise their hand.

DR. ENTHOVEN: 8. How many are opposed to that? 16. 16 to 8. That's the end of end. We'll move on to B.

MS. BOWNE: No, we still have an issue on No. 1 because that was only a piece of the discussion. I think the whole concept of No. 1 is really the continuity of care, and I think that certainly one would recognize that if a provider and a patient who are in an active session of care, you know, be that a pregnancy or be that a severe chronic condition or something, that that should continue. But the wording here implies that, you know, whether or not there's an active engagement there, that the person gets to go see their doctor until the end of the contract year or 60 days.

I think that we're really talking about here is if a patient is undergoing care, that they would continue that for a reasonable time period, being the end of the contract year or presumably the end of the pregnancy, which is in most cases is a finite period.

Then the other thing that isn't addressed here in all this is that if -- that's in the cases that

we're talking about where either it's non-renewed or something like that. Obviously one would hope that what gets injected here, that if it's terminated for cause which is, you know, notified and what have you and it would cause actual harm to the patient, that you wouldn't expect to have to continue that relationship, and this doesn't state that concept.

MR. LEE: Can we take those as both friendly amendments?

DR. ENTHOVEN: Rebecca, please give us some words here as to you're -- Rebecca, words please.

MR. ZATKIN: After the word "members" -- who are in for actively receiving care?

MS. SINGER: How about if they are undergoing a specific course of care? Chronically ill if they are undergoing a specific course of care, and then acutely ill and pregnant to continue seeing their doctors until the course of care, including postpartum care?

DR. SPURLOCK: Let me cut to the chase on that because then we'll come back to a couple other points. I was going to point out the language and the president's commission about transitional care because I think we're talking about, we all believe in continuity of care. I think that's a given that whenever relationships exist, should be continuous.

We're talking about that transition period for people who are changing providers and there may be a

whole host of reasons for that. One of the things that is not in this is the involuntary nature of if for the patients changing; so if it's for patients voluntarily changing their provider, we shouldn't mandate these sort of relations to exist. I think that needs to be put in there, and that's in this language.

I don't think we just do for any episode of care because that sort of care for some people with some illness goes on for 10, 15, 20 years. It's not so episodic that it's just like an asthma episode or a pregnancy; so this actually accomplishes that much more.

I want to say two other points. One of the things is that --

DR. ENTHOVEN: What are you saying?

DR. SPURLOCK: It's consumers who are undergoing a course of treatment for a chronic or disabling condition or who are in" --

MS. BOWNE: Slower. Slower. We've got a court reporter here.

DR. ENTHOVEN: Slower.

MR. LEE: "Transitional care: Consumers who are undergoing a course of treatment for a chronic or disabling condition or who are in the second or third trimester of a pregnancy at the time they involuntarily change health plans or at a time when a provider is terminated by a plan for other than cause should be able to continue seeing their current specialty providers for up to 90 days or term completion of postpartum care to

allow for transition of care.

Providers who continue to treat such patients must accept the plan's rates as payment in full, provide all necessary information to the plan for quality assurances purposes and promptly transfer all medical records with patient authorization during the transition period."

It encompasses --

MS. FINBERG: It leaves out "acute."

DR. SPURLOCK: The course of treatment -- course of treatment is different than care. I think it means that it's in that course. That's the language I want to talk about. There are a couple other points I want to make when we talk about this language with regulatory authority and contractual arrangement.

DR. ENTHOVEN: Bruce, what you just read is a substitute for what's there?

DR. SPURLOCK: Correct.

MR. ZATKIN: Alain, I would support that, but realize that adds a concept that is not in this recommendation because the way the recommendation was worded, it applies where you're in a plan and your provider is terminated. This deals with the front end as well; that is, where you were previously in a plan and you were -- you had to switch plans involuntarily.

Let's say you have a single plan. Your employer drops the plan, and so as a result of the employer dropping that plan, you had to switch

providers. This allows continuity on what we call the front end as well as the back end.

DR. ENTHOVEN: That's very important.

MR. ZATKIN: I would support that.

DR. ENTHOVEN: And it also includes that the provider has to accept the preestablished payment rates and cannot just jack up the -- and it has to report for quality purposes.

Okay. Let's take a straw vote. All in favor of the Spurlock Amendment?

MS. FINBERG: Can't we add in "acute care"? It's limited. Can you read that part again because it sounded to me like it was limited to chronic and pregnancy?

DR. ENTHOVEN: Shut up everybody. Let's just get your hands up and count everybody. Pardon me. My mother taught me that's a bad word. Okay. So the Spurlock -- now, would you kindly submit that to Sara or to me or Alice for incorporation in the record and put it on the Internet.

Any additional discussion on recommendation A-1?

MR. RODGERS: There was just one little comment I had. Although it does say "involuntary," is there a role for the consumer to make the choice of whether they do want to transfer early, to be involved in that decision? That's the only question I'll ask for the group to think about.

DR. ENTHOVEN: Well, or should we add to that "If desired by the consumer"?

MR. RODGERS: I think they need to be involved in the decision.

DR. ENTHOVEN: Could we just take that as a no brainer? It needs to be said and should be said, but if the consumer desires it.

Yes?

MR. LEE: I just want to say, I want to throw one more issue up and it may come back with a language when I get more comfortable with this. There is a concern on the part of many, many physicians that when this transition period happens, for the folks that don't necessarily have ongoing care, when they go from one plan to another plan, that the PMPM that goes to the physicians, the group, or the individual physician provider, doesn't necessarily start with that physician. In some cases until when they've that first visit, and even though the contract says it should begin the day that that happened; so I think there's some muckiness in that transition period or when there's a transition that some patients are not getting that PMPM right off the bat until they have that first visit, and it may be six or nine months down the road and they've walked that for component --

DR. ENTHOVEN: But we're talking concept here. We're not either legislating or regulating. We'll leave it to the regulators or attorneys to see.

This still is on A-1?

DR. GILBERT: Just a clarification for Bruce. Bruce, as you read that, the whole issue of non-renewal that we just discussed would that, if a doctor was dropped out of the network through non-renewal, would this continuity of care provision come into play? Because if it does, then it deals with the issue of patients being cared for after that non-renewal.

Do you read it that way?

DR. SPURLOCK: Yes.

MR. ZATKIN: What's the operative term?

DR. SPURLOCK: It says that "a terminator by a plan for other than cause." It's a terminator issue. It's not necessarily non-renewal.

DR. GILBERT: If we put "non-renewal" in that phrase, because we're looking at the care of the patient, which is the issue we're concerned about when someone is not remitted, would that take of the issue and then forgetting that there may be any remarks other than in terms of wanting to know this, if the patients are cared, if they get it from that same physician, don't we have the same practical effect we want?

MR. HIEPLER: It's a bit different because in the context, so many people were shaking their heads as to, I think, not knowing this. What typically happens is you get an oncology patient. Their oncologist is terminated in the middle of very crucial

therapy and they're being shuffled around, and you can be terminated not for cause for cause and your contract cannot be renewed with the 90-day notice, which is somewhere between, and that's the area that Martin brought up, and that is technically a non-renewal but it's notice on 45 days' notice that you're not going to be renewed.

DR. GILBERT: But still the overriding principle is that an individual's physician is moved out of the system, if that's the overriding principle -- but is still caring in that area and obviously still able to care for that patient -- the overriding principle is making sure the members that have medical issues, including that oncology patient, are cared for by that same physician, wouldn't that take care of the issue?

Isn't the issue fundamentally setting up a way to make sure that the member can access that care if they're that episode, whether it's non-renewal of termination or other than for cause only?

MR. HIEPLER: It's a patient-interest issue being able to continue because of the extreme nature of the treatment.

DR. GILBERT: Which is the non-renewal. Won't that take care of that?

MR. HIEPLER: I think so.

DR. ENTHOVEN: Okay. Is there anything else on --

MR. SHAPIRO: Very quickly.

MS. DECKER: I'll interrupt to say 50 minutes.

MR. SHAPIRO: I'll take 30 seconds. Wordsmithing, you say the regulatory agency shall require here, I suggest friendly amendment, governor and legislation to authorized and direct. The regulator cannot do this. If it's one of the mandates you're willing to do, be clear that somebody authorize it and somebody do it.

DR. ENTHOVEN: Thank you. Got it. Any other for A, continuity?

Then we'll move on to B: Gatekeeper roles, primary care physician and utilization review.

Yes, Dr. Spurlock?

DR. SPURLOCK: Thank you, Mr. Chairman.

One of the difficulties in crafting recommendations from this Task Force is not to be overly prescriptive, to be descriptive, and I think on this recommendation we've actually gone the other side of this spectrum, too broad and too descriptive of a concept.

I completely support the notion of severely chronically ill patients active to specialists and for ongoing care by the specialists for people with severe, chronic, and complex illness.

I think if you say that any chronically ill patient, which is the end of the first line, you basically opened up Pandora's box. There is a spectrum

of chronic illness from mild epithymic asthma, mild hypertension, to complex multiorgan systemic erythematosus, and there is no one in their might, right mind that thinks that a primary care provider should provide primary care to the person with complex multiorgan lupus, but I think there is some dividing line that happens along the way on that spectrum when we would all agree that the care should by primarily provided by the specialist and not by the primary care provider.

One of the ways to try to get around, and I thought of a lot of different approaches, is that if we take the notion that the primary care provider can authorize extended or prolonged or permanent referrals to a specialist, we do get out of that box. We allow, with that method, a discourse between the specialist and the primary care physician about where the care is best. It puts in that spectrum where we draw the line on which case, at the provider level, at the highest level, not at the health plan level, but at two physicians who should be able to reconcile those differences about where care should be.

One of the things that that provides is that a urologist who sees somebody with an enlarged prostates, for example, just an enlarged prostates, there's nothing else going on, would have to convince the primary care provider that it's that person's responsibility, his or her responsibility, to continue

this yearly rectal examination. That's primary care, and most primary providers would say, "I couldn't authorize that care. I can do that myself in the scope of everything else I'm doing with that patient." So make sure the dialogue and the convincing and the discourse happens with that.

If we just leave it where the way it's written, I think it blows up primary care providers. I think it's a specialty protection clause, and we just need to narrow it. So again the language would be something like -- and I don't have exact words -- that "purchasers should encourage health plans to allow the primary care provider to authorize all necessary and reoccurring visits and specialty care that they determine." And that way the primary care provider is in the loop and yet can authorize it so that you don't have to come back every time for multiple authorizations and gatekeeping.

DR. ENTHOVEN: Bruce, let's just make sure Sara got some of the those words. I think you're making a whole lot of sense.

MS. SINGER: I got it.

DR. ENTHOVEN: What?

MS. SINGER: I've got it.

MR. BOWNE: She's got it. Move on.

DR. ENTHOVEN: All right. All in favor of what Bruce has proposed, may I just have a straw vote?

MS. BOWNE: You don't need to count Alice. There's another hand.

DR. ENTHOVEN: Any other on the gatekeeper role?

DR. WERDEGAR: Alain, I thought the Spurlock suggestion was critical. I wondered in this section, are we simply going to refer to those other -- under "recommendations" -- to the medical necessity paper, to the dispute resolution paper, or shouldn't we reiterate the recommendations here so that if somebody is reading about patient-provider, provider-patient relationships, they can see under the role of the primary care physician or the gatekeeper role all of the recommendations?

The force of that would be so that you could really strengthen the role of the primary care physicians, like Spurlock did just now was very important, but also the issue of prior authorization, I think, was the other critical one, and that you might like to see a recommendation appear right here rather than to have to hunt for it.

MS. SINGER: Well --

DR. ENTHOVEN: Sara?

MS. SINGER: Let me just make a suggestion. We just didn't want to have to vote on it twice. We can definitely restate it.

DR. ENTHOVEN: Okay. I'd like to request that Sara just stay there because she is -- all the

papers have passed through her word processor and she's got it all in her head, and I don't. I mean I get confused, but she doesn't, so.

Lee, Rogers and Shapiro.

MR. LEE: Coming back to Bruce's note and as Alain noted yesterday, that there's an M word which he tries to avoid, which is "market," and the M word that I try to avoid is "mandate," but I'm concerned that this is not -- I'm fine with Bruce's clarifying language but not with the preamble of purchasers should encourage.

I think this is something that the state regulatory body should do and the appropriate mix of when do you have a standard of referral, when do you have a process that allows for that, I'm happy with that language that Bruce noted; but I think our advice and the purchasers should encourage is sort of nothing. I mean it's sort of a "Think about this as a kind of nice thing."

There should be appropriate cases where specialists should be provided ongoing care and not have to go back for authorization, and I think that that is not strong enough, and I'd appreciate a straw poll on that issue.

MR. ROMERO: Can I offer a compromise, Peter? What if the mandate was on public purchasers, who are about half the market?

MR. SHAPIRO: No. Just one thing to

consider: Other states have mandated the standing referral, not what's in the paper but the alternative that was here. But you're saying it's done; so I can go home?

MS. BOWNE: But, Peter, I'm a little concerned that we don't have this well defined on the other end. You know what I mean? In other words, I'm fine with the concept with the more narrow definition that Dr. Spurlock was talking about. I'm not okay if it's just for anything.

MR. LEE: I agree with that. And that's what I'm saying. I think that Bruce's language, I added to it, working that out so it's not just an door that you go "Oh, deal with a specialist forever." Fine. But I'm concerned with just saying that it's a recommendation purchasers are kind of encouraged to think about it isn't enough; so that's what I'm saying. I support Bruce's language.

MS. BOWNE: Well, I'm just saying before we mandate, I'd like to know what the language is on the other end. It's okay if it's restrictive enough. If it's too broad --

MR. LEE: I'm suggesting that do a straw poll on -- we'll have the language come back for the vote with the restrictive nature of it of what might the mandate be, but I'd appreciate a sense of the group on "it not just being" and "encouraged."

DR. ENTHOVEN: Brad, you're on the list.

DR. GILBERT: The only other thing I wanted to clarify, theoretically, Bruce, what you're saying can happen, can happen right now. I mean under theory, under managed care, under a utilization management system, a primary care physician can ask for a series of referrals or for certain periods of time and the UM Department should say, "Yes, that makes sense with this patient," but the fact is it isn't happening now.

I think the issue with our group was that there have been some plans that have looked at -- they've gone the whole other way. They said a member can choose a specialist as their primary care physician. I agree with you that we should somehow make this the set of members that actually need that level of care. But relying completely on the primary care physician, given the fact that that in theory can exist right now, and it hasn't, and that's why we're trying to address the issue.

Maybe another alternative is some way for the health plan to evaluate, based on the clinical issues of the patient, their need for assignment through a specialty care provider. Through some cases, all the care is given by the specialist and really the role of the primary care physician is really quite narrow and you're going from specialist to the specialist. You have your SLE patient that needs a GYN eval. You know, there are complications to that that you may want an

OB-GYN rather than a primary care practitioner doing that.

I would only say that I agree with you in theory, but I think why the group addressed it is because it isn't happening now.

MR. ZATKIN: Well, but it's a bit of a mother mask. Question: Is it not occurring because the primary care physician is constrained by the rules of the plan for the group in terms of referral, or is it not happening because the primary care physician has the freedom to do it but because of other incentives, doesn't?

DR. GILBERT: I would say a combination.

MS. DECKER: It's been 60 minutes.

DR. ENTHOVEN: A while ago I put myself on the list, which is a comment on Peter's suggestion. I just very strongly advise against legislating in the sultries of the organization of the medical program. I think it's a terrible mistake.

Dorothy Rice says 90 million Americans have chronic diseases, that they range all the way from very severe to pretty minor. They are full of gray zones. When I talk to my friends, the doctors, in some cases one primary care physician has trained for certain other things and another, he hasn't, then it's really has to be among partners or teammates to work out the division of labor that is appropriate under the circumstance.

When you try to wrap legislation around that and pour concrete and you get, in many cases, evasion because everybody agrees it's a silly law or it's not enforceable or if you try to enforce it, then you're going to have lawyers in the examining room, and so, Peter, I just want to -- it might sound limp, but I think that to use your phrase -- I just think that trying to set up a law around that is real distinct.

Not only that, I think that the market is moving. Oxford Health Plans got national publicity and other health plans are looking at that. Maybe it's obvious common sense that you're going to have your diabetic be able to see the endocrinologist regularly and so forth.

Rodgers? Rodgers and then Finberg.

MR. RODGERS: I support Bruce's change, but I'd like to point out something. The primary care physician today in managed care is a different function than it is in fee for service. We credential primary care physicians to have a scope of knowledge in terms of social services, et cetera, mental health, et cetera, that specialists don't always have. Now, we ran into this problem with ophthalmologists, and, you know, I couldn't believe it until we were doing our Medi-Cal network, and we have ophthalmologists who want to be primary care physicians; and so if you look at this and all I'm asking is when we do this, we don't create an unintended consequence of opening the door to any panel

person who claims to be a primary care physician.

There is a credentialing process that must be kept in place because we are expecting the primary physician to do a lot more, to be the medical home for the individual, and we're transferring that function to a specialist. They will be credentialed as a primary care physician and then have the other scope of knowledge they need to have to take care of that patient.

DR. ENTHOVEN: Finberg?

MR. FINBERG: Yeah, I wanted to speak to that issue that Peter and Allen discussed in terms of whether legislation is necessary. I think it is. The issue was up. Actually a bill was negotiated. The plans agreed on language on this issue to have a specialist named as a primary care provider in certain narrow circumstances for people with particular disabilities and, you know, it fell into that area of bills that couldn't obtain a governor's signature; so I think that it is important to be strong on this because it won't happen otherwise.

The encouraged issue isn't working now; so I feel very strongly that it would be very help and that there is an expectation for this Task Force to be issuing principles on certain issues. I don't think that is a micro-managed issue that requires particular medical expertise. It's a very general principle.

DR. ENTHOVEN: Peter, what is -- just give

me the phrase that you want you were going -- you want to mandate it; right? Because the phrase, I'm going to try to take a straw poll.

MR. LEE: Well, the phrase we used throughout is we advised the governor and the legislature should act to require health plans, and then Bruce's language. I'm not saying the language is the language here. There's allowed specialists, PCP's, I was going on, hanging on Bruce's language thereafter.

DR. RODRIGUEZ-TRIAS: I have problems with that term.

DR. ENTHOVEN: Let's see. So the governor and legislature would require health plans to do what Spurlock says.

MR. LEE: I'd like to call it the Spurlock Bill.

MS. FINBERG: Would you repeat your language?

DR. ENTHOVEN: Sara, would you repeat the language?

MS. SINGER: Yes. "The governor and the legislature should act to require health plans to allow the PCP to authorize extended, prolonged, or permanent referrals to specialists for chronically ill members."

DR. ENTHOVEN: Okay. Would those in favor of that please raise their hand.

MS. SINGER: Let me read it one more time.

DR. ENTHOVEN: You want another reading?

MS. SINGER: "The governor and legislature should act to require health plans to allow the PCP to authorize extended, prolonged, or permanent referrals to specialists for chronically ill members," and I also have a note that says we should work towards restricting that to a subset of members who need care.

MR. LEE: In terms of my language, I think that the -- Bruce's point was, I think, to put it all with the PCP. I think the intent of the legislature or the governor's action should be that "health plans should provide authorization for appropriate access." It shouldn't just be -- I think it can't just be purely a PCP issue; so my amendment would be to strike PCP, and the obligation is through the health plans to provide authorization, and I would be happy more spelling out the chronically ill.

DR. SPURLOCK: We've got a lot more to do on this paper, to discuss. Peter and I could work on some of that and we'll contribute it to Sara, and then we can vote on it and wordsmith it the next time we have to do it.

DR. ENTHOVEN: I just want to get a sense of the concept of --

MR. ZATKIN: Alain?

DR. ENTHOVEN: What?

MR. ZATKIN: I think it's current law. Isn't it current law if plan is denying appropriate access to specialists in violation of --

MS. SARA: There's nothing this specific in current law, but I think -- and I think something this vague is in the statute. There is a bill that is pending and the language that we discussed was that there would be an extent of standing referral or a permanent PCP relationship when the PCP recommended it in consultation with both the specialist and the plan medical director pursuant to a treatment plan. So there's very tight agreement that's been worked out.

MS. BOWNE: That's much tighter and better.

MR. LEE: I've agreed to work with Bruce on that sort of language that is limited but clearly provides for standing referrals in appropriate situations.

DR. WERDEGAR: Does the group object to changing the title of that section from "gatekeeper role, primary care physician" to "coordinator role" and striking the "and utilization review"? Just call it "coordinating role of primary care physician" because this tends to enshrine that notion that the primary care physicianS only arose out of gatekeeper?

DR. SPURLOCK: And many primary physicians look at that as a pejorative term.

DR. ENTHOVEN: Right. Is there objection?

MS. SINGER: Mr. Spurlock, the reason we added "utilization review" was because we felt that we wanted to talk about the fact that utilization review

goes on at the health plan level as well as the medical group level; so these just mirror the body text, and the body talks about more. I mean I use the coordinator.

DR. ENTHOVEN: All right. Bruce, did you -- I was going to take a straw poll on the concept of Peter's idea that the governor and the legislature should require this.

DR. GILBERT: Could we do it around Maureen's language, kind of around Maureen's language?

MS. SINGER: Why don't you just ask if it mandate versus -- you know, require versus encourage?

MR. ZATKIN: Yeah, but it depends -- this language that Maureen talked about is --

MR. LEE: It's typical of the mandate language that going --

DR. SPURLOCK: Let's wait until we get the language. We can amend it.

MR. ZATKIN: It's negotiated language.

MS. BOWNE: Since we don't know what we're talking a straw poll on, let's not.

DR. ENTHOVEN: Yeah. Okay. We're going to move on to C, informing patients of --

DR. WERDEGAR: Alain, I think on this next section, two concepts are intertwined, and it should be separated. One is the ability if a physician to inform the patient -- the provider to inform the patient, to be able to do so freely without gag rules and without fear of reprisal.

The other issue is separate from that communication and it's the communication between plan or consumer information and the consumer that let's people know about outcome, competencies and so forth. I don't think the two should be intertwined here. I would put the emphasis on freedom of the physician to communicate with the patient without gags and reprisals.

DR. ENTHOVEN: David, I do believe that is in Knox-Keene. We have already outlawed it; so I don't think we need to --

DR. WERDEGAR: The reprisal issue as well?

DR. ENTHOVEN: Warren Barnes, reprisals outlawed also?

MR. LEE: For what?

MR. HIEPLER: It's under Business & Professions Code.

DR. ENTHOVEN: Oh, under the Business & Professions Code. I had understood that that was --

DR. WERDEGAR: The otherwise way it winds up is that the whole issue of the patient-physician -- it looks like our only recommendation is to let everyone know about prior procedures.

DR. ENTHOVEN: Well, that's not insignificant. The President's Committee took that up and I think they concluded --

DR. WERDEGAR: Oh, it's an important concept. It's where it's placed. You see, this thing was all introduced, as I said earlier, by the covenantal

relationship between patient and physician. One important aspect of that is the freedom of communication between physician and patient.

DR. ENTHOVEN: I believe, acting on Mr. Barnes's and Hiepler that that's already in the Business and Professions Code and that's already law.

Okay. Peter?

MR. LEE: Are we on No. 3 now?

MR. ENTHOVEN: We're on No. 3, yes.

MR. LEE: This is a followup on David's point. I agree with this, but I also agree it should be at another location and with a couple modifications. One, I think the requirement list should include health plans, which are not listed right now. I also agree that there is a huge question about what we're ready to do in this area in terms of where we have outcomes that are prepared, and I think this needs to go in probably the consumer information piece, but there's need to be qualifying language "as appropriate outcomes are available and these should be made."

It shouldn't be so blank that everybody out there should be trying get people information that's not useful. I think that that qualifying language should to be there, and I suggest it be moved as well.

DR. ENTHOVEN: We don't have the outcome information in many cases. If some grievously ill person travels a long way to UCLA to get operated upon, they go back to their home, and some months later they

die; and the widow doesn't think of writing a letter to UCLA to say put this in your data bank; so that's not a very good data system.

That's a big concern I have about outcomes, but I think the thing about disclosing the number of procedures, "How many of you have done lately?" People are very embarrassed to ask about that. In open heart surgery we have hospitals in this state that are doing like 25 open hearts a year. It just amazes me, you know, how did those patients get there? What happened to their referring doctors? And that information --

DR. WERDEGAR: Well, you want the doctor in the plan to be able to say to the patient, "You know, our plan only sends our hospitals to schlock hospital, but I really would like you to go to Stanford to get your heart operation" and to be able to discuss that, that, I think, is the force of this particular section.

Well, but somewhere else that information should be made available. It's just where you place it. It's important. Nobody is going to argue with you that's not important.

DR. ENTHOVEN: At least on a number of procedures, we can take out "outcomes"?

MR. LEE: Leave it in. It needs to be where available --

DR. ENTHOVEN: When available.

MR. KERR: I think the random UCLA date

we've seen in our commission has indicated that, yes, it is better when you go above 200 and so on, but quite honestly, you get some schlocks about 600. So the public's got to know this as soon as we've got good data. It's key to know the numbers, but basically it's the outcomes that count.

DR. ENTHOVEN: Yeah. Even if we get the new quality information changed, "can do proper risk adjustment, measures, outcomes"?

MR. KERR: Right.

DR. ENTHOVEN: Then -- yeah. That's great

DR. KARPF: Risk adjustment becomes a critical issue. How can you have cases that when raw data look terrible, when risk adjustment looks quite good?

DR. ENTHOVEN: Right.

MS. DECKER: We're in an hour and 15 minutes.

DR. ENTHOVEN: What else on point 3?

MR. HIEPLER: Where did we leave that?

DR. ENTHOVEN: Where we are is "when available outcomes."

MR. LEE: "Risk adjusted outcomes."

DR. ENTHOVEN: Yeah.

DR. KARPF: Could I make a suggestion? There are a number of ways that outcomes become available now from state data to insurance data and one could say all available or all presently available

outcome data should be made available.

MS. SINGH: Dr. Alpert and then Dr. Spurlock, Mr. Hiepler, and Dr. Gilbert.

DR. ALPERT: I just have maybe a point of information and a question about -- I think all of this is fine, but the practical implementation of the physician telling -- responding to this or being required to versus the rest of these things. What really happens in day-to-day practice, in my experience, patients ask all the time, as a matter of fact, the majority of patients ask now because they tend to be very educated and they read a lot, how many of these have been done and so on and so forth. And I tell them if I know or I give them an idea.

The point about that is there a direct part of the interaction. If I don't satisfy them, you know, make a decision of whether to come to me or not and so forth and if they have that option, I don't know how -- and if somebody simply doesn't tell them, then I would think that's a pretty strong inducement not to stay there or they if seeing somebody defensive or say, "Well, gee, I've never done it," and whatever. And I put that juxtaposed to how to implement that.

In other words, I think this is great where it's hard for the person to get the information and so forth and so on, all the things you were talking about. It's also easy to implement and to discipline if it's not complied with. If the doctor -- if the patient

asked me, "How many have you done," and I said, "Well, I don't know," or what I want to tell you that, do they then call the agency and say I've broken the law by not doing that? I find the implementation is different on the one-on-one basis versus all the things here that everybody in the group put together.

DR. ENTHOVEN: Well, what we wish we could do is to create a professional norm where the physician was not insulted when you asked but was prepared to answer.

MR. RODGERS: Just ask the nurse.

DR. ENTHOVEN: Did that get on the record, "Anthony Rodgers: Ask the nurse"?

DR. ALPERT: I think the concept is fine. I just see a difference in the implementation and a follow through of it in the individual versus the institutional end of it.

MS. SINGH: Dr. Spurlock.

DR. ENTHOVEN: Okay. Dr. Spurlock?

DR. SPURLOCK: Thank you, Mr. Chairman.

Many people have said some of the points I wanted to make about the fact that this goes on now, today, and patients can ask me or my colleagues how much procedures they're doing. This issue really though is really one of the fundamental things from a morality standpoint because this is informed consent. In reality that's what we're talking about is informed consent. And I've given lectures on informed consent and I hold

this near and dear to my heart.

The problem, and I don't mean to offend my colleagues by this, but the problem in CCHI that we talk about whenever we talk about reporting information, is that self-report comes with perceptions of bias on it, and so we always talk about how do you validate that and how do you have an external source of self-reported information?

I think that with informed consent, you have to just have that discussion and dialogue with patients. I don't think so there is any problem with that, but for patients and consumers to have meaningful information, you can't use self-report information. It's not that it's not accurate, but you can't -- there's a perception that it may be inaccurate, and so you have to take that outside.

I think there was a discussion about moving this whole concept about -- that kind of information that Dr. Werdegar talked about -- into that paper about that kind of relevant information from a consumer, and I think we should be broadening to talk about informed consent of a patient when they're in their office with their provider about the kind of procedures they're going to have, and that includes, "How many have you done?"

Now, one caveat on that, we may be talking apples and oranges. We need to talk about cardiac bypass surgery, and yet there is cardiac bypass surgery,

but are you using this technique, that technique? You know, I think in the informed consent process, people need to know that providers practice differently even on the same procedure on what they do, and they need to have that level of understanding to make a good decision; so I would like to take sort of take a re-focus at this and look at more informed consent language and strengthening informed consent and the use of informed consent with patients rather than trying to go give out the specifics of outcome data, which are self-reported, really problematic with,

DR. ENTHOVEN: Dave, on your discharge abstracts, do you have the name of the treating surgeon for surgery?

DR. WERDEGAR: No. I don't think we do.

DR. ENTHOVEN: You don't? Because if you did, then you could just run the tapes and we could see how many open hearts Dr. Alpert did last year. Is there a conspiracy of silence here?

We could deal with this in the new quality information. It does not strike me that this a is heavy, onerous burden on anybody to say the procedure performing physician's name would go on the discharge abstract and then you could just run data on how many they have done on --

DR. WERDEGAR: I'm all in favor of it.

DR. ENTHOVEN: -- risk adjusted?

I'm not just talking about the outcome,

just the number of procedures. Where do we treat that? In new quality?

Will you pick that up in new quality?

All right. Well, now, suppose we -- Bruce, okay. Let's say we move the numbers -- by the way, the number of procedures that they've done, that's going to come back. There's a lot of people who really believe that that's an important piece.

Bruce?

DR. SPURLOCK: I think that can happen now. The question is --

DR. ENTHOVEN: No, it can't because the law allow him to require --

DR. SPURLOCK: I know how many bypasses I've done, and I can say I've 15 or 35 or 135.

DR. ENTHOVEN: But you just told us that self-reported information is not --

DR. SPURLOCK: I agree that we need to have drilled down data on every procedure that we have. I think that's a huge Herculine effort to get there, and when we talk about new quality, we'll talk about that. I am fully supportive of that idea.

DR. ENTHOVEN: Now, then, did you want to put some other language in under C about informed consent?

DR. SPURLOCK: That is what I was trying to get at is to strengthen informed consent or the use of informed consent. To be honest with you, I have not

spent as much time on that so I don't have language to offer right now to the group, but Helen and I were talking a little bit. We might be able to come up with something that we could put into here.

MS. O'SULLIVAN: But I would like to not lose this.

MS. RODRIGUEZ-TRIAS: No. That's the broader frame work. The informed consent is part of it because at the point somebody reaches the informed consent process is when they're already sort of in the pipeline for a procedure.

MR. ENTHOVEN: Right.

MR. ZATKIN: Should it be every procedure? I mean how encompassing is that? Would it be every procedure?

DR. SPURLOCK: One thing about informed consent is you can't be event oriented. If you are event oriented and perform consent, you've lost the ball because, you know, care is a process. It starts when the patient accesses the system and it ends when they exit the system, and everywhere along the way, we have to have informed consent. We can't just wait until somebody is just going to get a procedure, and the best example of this is on prostate cancer testing, on the PSA test.

If you don't have informed consent before you can draw the blood about the implications of that test, it has nothing to do with the procedure at all.

I'd like to strengthen that whole thing so that we have better informed consent from A to Z.

DR. ENTHOVEN: I think what we're going to do is pass on C for a while, and at the end of this, we'll see if we can come back.

Now, we're going to move on to D, financial incentives. We discussed that in the provider financial incentive papers, but I know that Mark feels very strongly that these actual financial amounts should be disclosed. We did have a straw vote on that before, but if, Mark, if you want to call for a straw vote on that again, it's your privilege.

MR. HIEPLER: And I think it goes to the fundamental aspect of the ability for the patient to trust and be involved in the procedure because it's the patient's money, not the employer's money. It's part of the patient's money, even as a benefit. And the optimal check for the patient is to know who is capitated in the system so that you can guard against abuse and know why it is such a good thing. And then one step above that is to know exactly not just how much they're paid, but how many people are in there because we never have anybody people coming forward saying, "This is actuarially sound," and that's how, at least, allegedly capitation proves to be a good thing.

If you could have the number of patients under this capitation arrangement, then you'll know the type of insurance adjustor your doctor has been forced

to become.

DR. GILBERT: Mark, I don't know that there is enough support around the specificity of the dollars, but what we didn't address in the provider incentive paper was method and scope of the financial arrangements which would deal with your issue of, yes, we capitate them and we capitate them for the following services.

We have two points. One is don't just say we capitate them, also explain what those services are that they're capitated for. The second is the dollar figure. Would that -- and I don't know whether the group would support of the scope -- you know, just adding "scope" to that language, "method and scope of financial arrangement"?

DR. ENTHOVEN: I think that's a friendly amendment that can go without saying, "method and scope."

Mark, would you like us to take a straw vote on that?

MR. HIEPLER: Sure. I want to see how far I'm going down in defeat on that one.

DR. ENTHOVEN: You can waive it if you want.

MR. HIEPLER: No, no, really.

MS. BOWNE: Mark, the other notion that's going on here is that it's the whole practice of insurance and the spreading of risk and certainly if an

individual patient is told, "My doctor receives $2 per member per month for my care," and no rational person would think, "Gosh, how can my doctor take care of me for $2?" So then that's the comfort --

MR. HIEPLER: No. That's why I added in there that they should know how much and how many patients are at that level because then you might know that you're dealing with a volume person who can't possibly care for you.

MS. BOWNE: Well, as I'm saying, you're digging a deeper hole.

DR. ENTHOVEN: All in favor of disclosure of the dollar amounts of the capitation payments please raise their right hand.

8.

All opposed to dollar amounts?

17.

Without objection, we would accept method and scope -- I mean "and scope of."

MS. DECKER: Alain?

DR. ENTHOVEN: Yes.

MS. DECKER: It seems like Brad was saying -- I heard scope meaning what is covered: office visits, lab --

MR. ZATKIN: Class of services.

MS. DECKER: Yeah, types of services that were included, but I was hearing how many people are capitated on the same base in the practice over here

now.

DR. ENTHOVEN: No.

MS. DECKER: No?

DR. ENTHOVEN: No. Those types of services.

MR. HIEPLER: No. What I was saying is to make the number fair because Becky has the concern of the $2.

MS. BOWNE: No. I had the opposite concern of what you're alluding to.

DR. ENTHOVEN: I want to move forward, then. Position availability, E?

MR. HIEPLER: You had the concern of the $2 to be taken out of context.

MS. BOWNE: Right.

MR. HIEPLER: And you can put that in context by showing how many members you're getting at $2.

DR. ENTHOVEN: Okay. B-4. Now, Brad Gilbert has revised the wording so that -- I have notes, but do you have a wording here --

DR. GILBERT: It was if a patient is specifically assigned or chooses a physician as their primary care provider, but is directed by the group for the health plan to an alternative provider, an APN or PA, there must be verbal disclosure of that change in primary care relationship.

DR. ENTHOVEN: Okay. Have you got that,

Sara?

MS. SINGER: (Nodding.)

DR. ENTHOVEN: Do we need a straw vote on that?

MS. O'SULLIVAN: I just have a question. In that, we're acknowledging to the patient and consented to that change and primary care provider; right? It almost sounds like -- it could be read to say, "If this is disclosure, you can just change somebody's primary care provider," and don't mean to say that, do we?

DR. GILBERT: No. What I meant was that if this is disclosed, then the patient says that's okay.

MR. RODGERS: Can I point out something? This particular way that you've said it, affects county facilities, clinics, fairly qualified free-standing clinics that contract the managed care because they're the ones that move providers, as you know, back and forth; so one minute you have a nurse practitioner, the next time you come in, you have a physician. Are you going to imply that same logic to those clinics?

DR. GILBERT: Yeah, because I think the logic here is if the member is assigned or chosen a physician, we need to tell them if that physician is not available because what happens practically is they call for an appointment, and they say, "Well, you know, Dr. Jones is here, X, but, you can see so and so." If they make it clear, they say, "You can see this

alternative provider who is a nurse practitioner or PA,' then the patient consents to that.

MR. RODGERS: Okay. That effects residency training clinics. This is a dilemma because the way residents, even though they have more continuity -- I'm just saying all the unintended consequences mandating of that --

DR. GILBERT: But the mandate is simply that the patient is informed that they are seeing someone other than their assigned physician.

DR. ENTHOVEN: Brad, don't you always have a name plate which says "Sally Jones, MD?"

DR. GILBERT: No.

MR. HIEPLER: Brad has some good practical stuff. Brad, tell him.

DR. GILBERT: All I can tell you is that we have numerous quality care issues around, and it occurs more with certain types of practitioners than others, of the staff and of the individual introducing themselves as the doctor when they're not a doctor. And all I'm saying is there should be disclosure around that change in relationship of your provider.

DR. ENTHOVEN: I'm just wondering why they don't a have a name plate that says that.

We're going to do a straw poll on Brad's disclosure requirement. All in favor?

Okay. That's a pass. Now, I think that item F-5 is really dealt within our consumer information

as well as in -- yeah, oh, basically there. Also what it's really saying is these good guys who are doing these good things ought to go on doing it. I don't think that they even need to be in charge because they're way out front of the rest of us driving hard; so I'd like to take a straw poll for dropping 5 -- F-5 so that we can all go take a break.

All in favor?

Thank you. That passes.

DR. WERDEGAR: Alain, just because you might declare a break right now, I wondered if there should be a 6 that has to do with confidentiality, a paragraph that has to do with confidentiality? If you wordsmith --

DR. ENTHOVEN: We will come back to it; no, not now. After the break we're going to call on Bruce and Helen for words under topic C and we're going to ask you for a brief, concise statement. I'd appreciate it if you would share it with Sara so that she has it in the records because I agree with your confidentiality. It's important to all of us.

(Brief break.)

DR. ENTHOVEN: Members please resume their seats.

There is going to be five minutes of discussion of each of two points, and then I'm going to have just pound the gavel. One of the points which is already wordsmithed, Diane Griffiths and Dr. Werdegar,

it's just wrapping up the physician-patient relationships, very quickly now. Dr. Werdegar raised the point that we ought to say something about confidentiality because that is a very important part of the trust that goes into the physician-patient relationship. I'm sure nobody doubts that and so Diane and Dave got together and suggested the following:

We just lift words from the president's commission with permission for us to do some editing, to compress it, and make it fit in with the rest of the story. In other words, we're not making a contract that the words be precisely this way but, in good faith, close to this way and we'll interact with Diane on this.

So "Consumers have the right to communicate with health care providers in confidence and to have the privacy of their medical records respected. With very few exceptions, individually identifiable health care information should be disclosed for health purposes only, including provision and payment of care. Information should not be released unless authorized by patient, consent, or by law. Consumers would have the right to copy and" -- "should have the right to copy and correct their medical records and find out what is in them, how they are protected, and who is looking at them."

Dave -- I'm sorry, Michael.

MR. KARPF: I agree with that principle. There is one issue that, I think, needs to be clarified.

I think that if we are going to do large database outcome studies, we have to able to have access to patient information that's not attributable to patients where you just can't get it done. We've gone to the trouble of trying to get that through in informed consent in our institution, we do that, but not everyone does that. And so it will -- unless we have that, it retarded the ability to get large database information systems.

DR. ENTHOVEN: Michael, I couldn't agree with you more, but I think when we say "individually identifiable"?

MR. KARPF: Okay. As long as we say that, yes, "individually identifiable."

DR. ENTHOVEN: Okay. Other -- yes, John. Oh, welcome.

MR. PEREZ: Thank you. Since there was reference to specific exceptions, I was wondering what some of those exceptions might be and if can give a couple of examples that so it doesn't get misinterpreted.

DR. ENTHOVEN: Okay. Sara or Diana, are you -- Sara, just stay here at the table, please.

MS. SINGER: All right. The federal government actually does in a different document list several examples, and we'll have some examples of those.

DR. ENTHOVEN: Do you happen to recall?

MS. SINGER: It's in your briefcase.

DR. ENTHOVEN: Oh, it's in my briefcase?

MR. PEREZ: Since we're not taking a vote, as long as we have that information when we do take a vote, that's great.

DR. ENTHOVEN: All right. Yes, Michael?

MR. SHAPIRO: The legislature had an oversight hearing on the issue and the biggest problem was health plans asking individuals to waive their right, and that was considered consent as a condition for getting medical care; so it's not sufficient to say consent. It's like "Oh, there's issues," but you shouldn't have the consent for anything except for the things you just listed. They waived their right to the commercial use of that as a condition for providing medical benefits; so I think you want to qualify if it you can.

You can waive it -- you can give your consent for the purposes of writing medical care payments on those things, but you shouldn't have to be forced to waive by consent for purposes not related to care, and that's the problem.

DR. ENTHOVEN: Okay. "Or shouldn't be asked to waive for purposes other than care."

MR. SHAPIRO: Right.

DR. ENTHOVEN: Is that how all those drug companies got my name on their paper? Could we just go a little further on that?

All in favor of confidentiality please

raise their hand. All right. Done.

Now we'll call on the Spurlock, Rodriguez-Trias subcommittee who has wordsmithed on C.

DR. SPURLOCK: This is open for revisal improvement. It would go something like this.

DR. ENTHOVEN: Slowly. Slowly so we can follow.

DR. SPURLOCK: "Information on quality of care process and outcome should be collected and disseminated as discussed in the paper on improving quality information. As information becomes available, physicians should include all relevant information at every level of care in the informed consent process. To the extent that information is known, accurate, and reliable, a physician and hospital should make available upon request all relevant information regarding their experience and qualifications regarding the course of care patients are considering."

DR. ENTHOVEN: What about available to patient -- what about to someone like consumer reports or PBGH that wants to publish a Leak table or a display or something? Let's say that PBGH would like their members to have that, does that include that or is it the only in the doctor-patient?

DR. SPURLOCK: I think the notion was that in the paper on quality information, we would talk about how do we get that kind of information out to consumers, and I think it should have that. But this is pretty

much trying to get to that informed consent process.

DR. ENTHOVEN: Questions? Any questions about that? Yes. This would be a replacement for the existing C, and you will provide a written to describe -- yeah. Did you get it or --

MS. SINGER: No.

DR. ENTHOVEN: He'll provide it to you.

Okay. People ready to vote on that?

All in favor? It passes.

MS. O'SULLIVAN: Dr. Enthoven, I have something that I believe will be very quick in the spirit of things we've already talked about. On page 5-E, we talked about if a person has chosen a physician as a PCP and then there is going to be a change that they be informed. What would I like to change it to is "if a patient has chosen a PCP and there is a change in that, that they be informed." So if it's a change from one PCP physician to another PCP physician, or if it's a change from a nurse practitioner to a doctor, that any change in PCP, the patient be informed.

MR. ROMERO: So even if this category stays the same, but the individual provider changes that they be informed?

MR. O'SULLIVAN: Right.

DR. RODRIGUEZ-TRIAS: Yes, that makes sense.

DR. GILBERT: Well, I mean the intent, and I think that works with it well is that if you've chosen

or been assigned a specific doctor, if we're going to go to doctor-patient relationship or any primary care provider, they have chosen that relationship. If that relationship is shifted somehow, then the person -- it needs to be made known to the patient. Is that what you're getting to?

MS. O'SULLIVAN: What I'm saying is that no matter who that PCP, even if I have chosen a nurse practitioner as my PCP.

DR. GILBERT: Okay. I correct myself mid-sentence. You're right.

MS. O'SULLIVAN: Great. Thank you.

DR. ENTHOVEN: Now, during the lunch break, I delegated you two as the ERG to come up with an agreed wording and make it available to Sara.

MS. O'SULLIVAN: Sure.

DR. ENTHOVEN: I think of that as a respectable and friendly minute. Thank you very much.

Now, let's see. We are ready to move on to the regulatory organizational paper.

MS. DODD: Mr. Chairman, there is public testimony on this subject.

MR. ROMERO: While the chair is engaged, I would just like to thank Dr. Karpf for supplying our munchies this morning and our bagels.

MS. O'SULLIVAN: If we're taking a minute to do thank you's, we'll be rushing out of here at the end of the day, but I want to thank all the staff, the

staff DHS and the staff at Stanford and our chair and executive director for what they've done, but mostly what they're going to do in the next month.

MR. PEREZ: And, Phil, don't think that's not going to cost you a lot.

DR. ENTHOVEN: We have to take these in the order they came. We have Catherine Dodd. Please try to make it just as brief and concise as you can.

MS. DODD: Catherine Dodd here of the American Nurses Association of California. I'll state it pretty brief and concise. I want to thank you for the last friendly and technical amendment change you just made, but I wanted to point out that we believe that the informed consent about primary care provider should go both ways and that it should -- that in order for me to choose who I want, I need to know who's available and right now it's on a health plan by health plan basis what my choices are.

I was talking to people in the audience; and he said, "Yeah, my wife always make the appointment on Thursday afternoons because she because that's the only day the pediatric nurse practitioner is there," but you'd never know that because the pediatric nurse practitioner isn't listed in the material. So we believe that if we are participating in collaborative partners and providing care, we should be listed as providers in that care.

I also want to refer back to the first

page, and Dr. Werdegar talked about the importance of a covenant, and I venture to say that if it weren't Cardinal Bernardin who gave that speech and it was instead a Mother Superior, she would have pointed out that that same covenant occurred with all the health care providers that are engaged in patient care, and the public does not just exist between the physician and the patient. But I think about the social workers who provide mental services who are a core part of our health care system.

I would also express that I don't think Cardinal Bernardin was ever part of the managed care system. He probably never had exposure to the university, and I would like this document to reference that covenant and that importance between all the health care providers.

I realize the legislation itself says "physician provider," and I know you discussed that, but I think it was clearly the intent of the legislature to include all of us. Similarly, I would like all of us to be included in the protection form the gag rules so that maybe the physcian is protected, but everyone else needs to be protect too in terms of viewing all accurate information from all the patients.

I would really, again, request that this document be more provider neutral so that it really does reflect managed care and not the traditional Dr. Welby-Conswallo relationships that were given.

DR. ENTHOVEN: Thank you. We will put in the word processor quote, "appropriate health care professionals."

MS. DODD: And lastly with the regard to the first change that you kind of adopted by early morning fatigue, I think, the listing of appropriate health care groups, if we just kind of list them appropriately. I don't object to saying "appropriate health care organizations and professionals get appointed to these Blue Ribbons committees," as long as no specific organization then is listed; so if you're going to list the California Medical Association, then you need to list it specifically. If we are not named, we are not included as referenced by the number of nurses who are on this commission, this Task Force.

DR. ENTHOVEN: Thank you.

MS. O'SULLIVAN: On that last quote, can we take some agreement on that, that if we're going to say "appropriate health care providers," that that be the only we mention, that we not say "doctors and other appropriate health care providers"?

DR. ENTHOVEN: Well, we can take a vote on it. I don't agree with that at all. I think that there is a specific -- physicians have a specific role in this whole thing and it's legally defined and protected and when people are sick, really sick, they want to go to the doctor. I'd be comfortable with "physicians and other appropriate health care professions," but I think

if you want to reduce doctors too in the same category as all the others, you go against what at least was the original intent of legislature.

Maryann, I'm very happy for us to take a straw vote on that and see. So the proposal would be we just say -- we stop talking about doctors and stop making them a privileged class but instead --

MS. DECKER: Why don't you say "physicians," if you means physicians because doctors are a lot of different people, including yourself.

DR. ENTHOVEN: Right. We're saying physicians here. I'm sure I was speaking colloquially. As for Cardinal Bernardin, by the way, he was speaking to the AMA House of Delegates that particular day in his defense.

So, Maryann, would you like us to just --

MS. O'SULLIVAN: Yeah.

DR. ENTHOVEN: Okay. So your proposal would be, we just say "health care professionals" and don't single out "doctors"?

MS. O'SULLIVAN: Correct. For Task Forces that we're creating and different entities where we're saying -- so the different entities that ought to be on there. If we think health care providers ought be on there at all, we say it generally, "Don't worry. Doctors will be on." I mean we don't have to worry that 'doctors' won't get on these things.

MR. PEREZ: Mr. Chairman, I share the

concern, but I'm afraid that if we just say "appropriate health care providers," people are going to say, "Okay. We'll put a bunch of doctors on there," which is fine. But if we say, "doctors and other health care providers," then we're saying it shouldn't just be physicians.

I mean I understand the desire to have the list of all the different reasonable health care providers that should be included, but obviously -- and I think she's right to point out there aren't any nurses. There aren't any nurse practitioners on this Task Force.

DR. RODRIGUEZ-TRIAS: There are.

MS. FINBERG: No. But she's standing in as a consumer, not as a nurse.

MR. ZATKIN: What is this subject of the Blue Ribbon panel that we're talking about here?

MS. O'SULLIVAN: I'm saying generally, Steve, that all the different things that we're creating, that we put "providers" on there.

DR. ENTHOVEN: We're going to take a -- Okay. All in favor of "health care professions" as opposed to John's suggestion, "physicians and other health care physicians," please raise your right hand.

MS. DECKER: For what purpose?

MS. O'SULLIVAN: For the various Task Forces that we're creating, various Blue Ribbon --

DR. ENTHOVEN: For general purposes.

DR. RODRIGUEZ-TRIAS: But that's to accomplish a broader representation?

MS. O'SULLIVAN: Yes.

DR. ENTHOVEN: All in favor of that?

7.

All opposed to?

DR. RODRIGUEZ-TRIAS: We're not opposed.

MR. PEREZ: We're not opposed.

DR. ENTHOVEN: Okay. The alternative would be John's version.

MR. PEREZ: Because I think the most important thing is that we value the participation of a broader group of providers at the table.

DR. RODRIGUEZ-TRIAS: Exactly.

DR. ENTHOVEN: All in favor of "physicians and other appropriate providers"?

Mark, do you have your hand up?

16. The "physicians and other providers" have made it.

All right. Janet Moro, California Coalition of Nurse Practitioners?

(No response.)

MR. PEREZ: We're not going to amend Cardinal Bernardin's words.

DR. ENTHOVEN: Maureen O'Haren?

MS. O'HAREN: Thank you members of the chairman and members of the Task Force. I just have a few quick, cleanup points. I've provided the staff with

copies of existing law and pending legislation that deal with some of the issues that you went over in this paper, and I think the paper should recognize existing law where it is, and there is existing law pertaining to maintaining continuity of care with a former provider when an individual is voluntarily forced to change health plans.

We've already had a bill on that and we've dealt with that problem, and now there is pending legislation to deal with the issue that you discussed today of providers terminated and you want to maintain that continuity of care, and I think the amendment adequately addresses that. There is also law on the books that requires the plan to provide a notice within 30 days when the group or provider is terminated and perhaps it needs to be amended to include non-renewal, but that doesn't exist.

Finally a new issue. You've provided some language on confidentiality so that it should be used only for health care issues. I think we need to be careful about that because the plan, for example, will have a medical record that they have used make a decision about the care, and if there is a denial and then a subsequent grievance, the plan wants to be able to use them as a medical record in the grievance process rather than have to go back to the member and ask for consent to disclose the forms again, and that will slow down the grievance process.

I think when we get to the dispute resolution paper, I think you're pushing for a faster turnaround time on that and so you don't want to have all this mailing and consent forms going back and forth, which will just slow you down; so I think that language should be -- maybe there should be some care in crafting that language.

DR. ENTHOVEN: Could that be one of the exceptions? "Use in a formal agreements process."

MS. DODD: Well, I don't know that we want to create a list of exceptions because we may not include everything or decisions related to the person's care. I think we just need to be very careful not to seem too limiting.

MR. GRIFFITH: Mr. Chairman?

DR. ENTHOVEN: Yes.

MS. GRIFFITH: The language that we use, it explicitly said that it could be used -- that using if for health purposes included the provision and payment of care.

DR. ENTHOVEN: Okay. Thank you, Maureen. I appreciate your point about it, but it's already in law. We don't need to reenact it. We need to give recognition to existing law, and I appreciate, Maureen, your support and your working with Sara and Diane on that.

There are two or three times when I've said I thought that was in the law already. I might or

might not have been correct, but we'll try to clarify those issues, and I trust the Task Force will agree that in the editorial revision process, if something is already in the law, we can state the law and we don't have to -- if we just make it clear that we're intending to go beyond the existing law.

Yes?

MS. O'SULLIVAN: I'm just a little nervous if representatives from the health plans are telling us to set this in law and if people here are making these recommendations based on our perceptions of the problems going on, then maybe we at least want to say, "There needs to be more rigorous enforcement of existing law," or something, but to not lose the whole issue because somebody tells us, "Oh, it's existing law."

MR. ENTHOVEN: Yeah. Okay.

MR. LEE: The other observations is that a number of things that are in law that reflect oversight of Knox-Keene registered plans don't carry across to other managed care plans. This may not be one where it matters, but there are other reasons we make recommendations because of the inconsistencies of oversight, so that's where we need to cite that they're relevant in law for Knox-Keene.

DR. ENTHOVEN: Next is Beth Capell, California Physicians Alliance. Have you changed jobs over night?

MS. CAPELL: No, I have multiple clients,

sir. I represent the California Physicians Alliance as well as Health Access and others.

Specifically on the point you were just discussing, we will look with interest at the amendment that Mr. Spurlock offered with regard to A on continuity of care with physicians. We are concerned that that may be construed to be narrower than existing law, the Knox-Keene Act, which provides for continuity consistent with good professional practice, and that there may be -- by being more specific, we may have inadvertently excluded situations that are inconsistent with good professional practice; so we will review that with care. That was not the sense I had of the discussion that that was the intent of this group, but the pending legislation which Ms. O'Haren referred to, we believe, does narrow existing law by making it more specific; so we are sensitive on that issue.

Second point I wish to make is that the discussion on termination of physicians and other health professionals, whether it's by termination of an existing contract or failure to renew a contract has focused exclusively on continuity of care as if the only damage that could occur to a patient is in the process of handing off a patient from one health professional to another.

Our organization has provided substantial testimony not only in this setting but in others that more considerable damage is done by the chilling effect

on practice. And Dr. Jeannie Gruer, who spoke with you, Dr. Enthoven, during the rap incident, I believe, conveyed to you her experience as the AIDS specialist in a medical group in which she was discouraged from seeing additional AIDS patients because she was a high-cost provider. The cost there is to and was -- had the renewal of her contract with that group, her sole group.

DR. ENTHOVEN: I think recognition of that problem animated our risk adjustment payments to providers.

MS. CAPELL: And we very much appreciate that; however, we believe that non-renewal -- what happened in this industry is that as soon as the law shifted to require that a reason be given for mid-contract terminations, the entire industry shifted to annual contracts and, in most cases, the failure to continue the relationship came as a result of that annual contract not being renewed; and so that we in an environment in which most physicians have more than half their patients from a single medical group, that has a very chilling effect; so we would encourage a revisitation on the issue of non-renewal of contracts.

DR. ENTHOVEN: Thank you very much.

MS. O'SULLIVAN: May I ask, who is the appropriate staff person? Is it Sara, about what existing law is on this so that we don't come back with a recommendation that's less than existing law?

MS. SINGER: On the informed consent?

MS. O'SULLIVAN: On the continuity of care issue.

MS. SINGER: It's very vague.

Steve, can you recite it, you probably know this provision?

MR. ZATKIN: No, I don't.

MS. CAPELL: If I might, this is an issue where it is in some sense a matter of interpretation of existing laws, the mere recitation of the words would not suffice.

DR. ENTHOVEN: Mary Griffin from the American Medical Group Association. The next person is Mary Griffin. The clock is started.

MS. GRIFFIN: It's short. It's three minutes, as I understand, Mr. Chairman.

I want to thank the panel today. You've addressed most of the issues the American Medical Group Association had and just for those who don't know, the American Medical Group Association consists of approximately 26,000 physicians in California in the capitated managed care environment.

I do want to just correct something that Beth said. The understanding I have from all the medical groups that I represent is that we're moving to Evergreen contracts, not to one-year contracts. So in fact, I just need to bring that out. It's less expensive for us to have Evergreen contracts, and that means they are on a continual basis until terminated.

DR. ENTHOVEN: As between the group and the health plan. What about --

MS. GRIFFIN: No, No. Between the groups and its subcontractors; so a lot of our medical groups will have subcontractors out there and they will have Evergreen contracts with those.

DR. ENTHOVEN: You mean so the practicing doctor --

MS. GRIFFIN: In perpetuity --

MS. BOWNE: You're eating into her three minutes.

DR. ENTHOVEN: Yeah. Okay.

MS. GRIFFIN: Thank you. And I would like to say that we do reserve some comments. I think you came up with some very good substitutions for this particular case, and we would like to see those in graphs and perhaps then comment. Thank you.

DR. ENTHOVEN: I was happy to hear from you. Thank you very much.

Okay. Now, we go on to regulatory organization. We ought to be able to get in an hour of this before lunch. Dr. Romero will lead the discussion. Our focus will be on pages 1, 2, 3, 4, 5, 6.

MR. ROMERO: 5.

DR. ENTHOVEN: 1 through 5. Pages 1 through 5 of "government regulation and oversight of managed health care findings and recommendations." We're going to have to spend -- we're going to try to do

this in an hour before lunch so that we may have to spend some more time -- timekeeper, timekeeper, would you call out, keep reminding us of how we're doing against the hour?

I recognize that because this is a new and large and important issue which hasn't been seen much before, we may have to spend more time.

Phil?

MR. ROMERO: Thank you very much, Mr. Chairman. The paper you have in front of you is the consolidation of two papers many of you have seen an earlier version before. One on regulatory organization. I've distributed an early draft to the Task Force at the Oakland meeting in late August. The second, the streamlining paper that many of you have seen as well, it's a joint product my myself, Alain, Sara, and others, and I want to particulary,among the "others" single out Jennifer Teshira and Terri Shaw.

Let me refer you first by way of factual background to page 10 of the main paper, where you'll see a chart there. This is a chart that those of you at Oakland have seen before. All it simply is the rows represent different regulatory functions or different public policy goals of regulation, and the columns are different regulatees or categories of regulatees, groups as financial intermediaries, providers, or facilities.

What go in the cells are simply a summary of current law regarding what state organizations are

responsible for regulating those entities in terms of those specific objectives, regulatory objectives. What you'll note there is that, as often has been commented on, the substantial -- there's substantial duplication. For that reason -- well, substantial duplication.

Several impacts, one that springs immediately to mind is confusion on the part of the consumer over "Who are you going to call?" Second, the different organizations that reflect -- different regulatory organizations that reflect different philosophies, may have, will have, do have different fee structures so there's not a level playing field with respect to levying the costs of regulation on the regulating fees, and they can have different approaches to accommodating the innovation of new products by the regulatees. For those reasons -- and now I'll shift from prescription to the recommendations -- for that reason, we are recommending substantial consolidation.

Now, I will talk for the next few minutes at two levels: Recommendations that are in the paper and then I want to highlight some things that have emerged to me as particularly controversial or worthy of your attention.

First, in terms of the columns of that chart that I just pointed out, which kinds of regulatees should this consolidated organization be responsible for overseeing? The common principle that emerged was if you're a segment of the health industry that bears risk,

financial risk, I.E., if you're responsible for pulling patients and then arranging their health care, then you should be consolidated in a single regulator.

I will point out --

MR. ZATKIN: Phil? Question.

MR. ROMERO: Yes. Sure.

MR. ZATKIN: You said two different things. If you bear risk, that's one thing; and if you're responsible for arranging --

MR. ROMERO: I'm just about to get to that, Steve. And in particular, that distinction is one of the elements of controversy. The paper specifically recommends that PPO's and EPO's, the regulation on both, be consolidated along with more traditional -- well, Knox-Keene Plans in the same organization.

Secondly, well, there's a subtext that runs through a number of the regulations that this consolidated regulator should be responsible for quality as well as for more traditional, financial regulation. Now, there are two ways in which to do this consolidation. One way, as recommended in the paper, is a new stand-alone organization which the working title we have in here is the Office of Health System Oversight. The other is a basic strip down in re-configured Department of Corporations.

In the latter case it would involve, in essence -- corporations, as many of you know, has -- besides Knox-keene regulation, their original mission

and some would claim still their dominant culture is securities regulation. So under the DOC option, this would involve transferring the securities regulation, the non Knox-Keene role out of DOC, probably renaming DOC to probably something that has the word "health" in the title.

The last detail I want to mention is about the leadership of this consolidated organization. The paper comes down clearly recommending that that leader not be elected; so in essence, that's code for saying this is not something that should be within the responsibility of the insurance commissioner or any other elected official.

It does recommend, and I point this out because I think this will be the subject to a lot of controversy -- the paper does recommend that the leadership of this organization be a single-appointed director, and the findings and recommendations section has a long list of desirable characteristics of that single individual.

It has been argued, I think with some justification, that that person would have to be a superman or superwoman to actually incorporate all those desirable characteristics. So therefore this is an alternative, and Martin Gallegos distributed a memo -- a letter to the Task Force authority yesterday, offering a suggested alternative which is have the leadership and consent of the board.

He had a specific violation in which -- and I'll let Mart speak to it -- but as I recall, he recommends five members with one each appointed by the legislature and one each appointed by each House and the Legislature. The governor has the majority of the appointments and, in particular, appoints the chair.

The advantages of a board are, No. 1, you can have a portfolio of skills, talents, and consistency perspective by the virtute of the fact that you have several leaders involved, and you can have more stability if you have staggered terms for those board members. The disadvantage, in my view, is that I think you lose some upward accountability because you're disfusing that leadership among several people, and I don't think there's a -- there may be ways to -- there may be ways to soften that tradeoff, but I think it's just a fundamental function of the individual versus joint leadership.

There are also a number of recommendations regarding the process by which financial and quality audits could be streamlined and, Sara, I'm sorry to put you on the spot. I should have talked to you beforehand, but if there are any comments you'd like to make about that, I prefer to do it rather than have me interpret your writing.

MS. SINGER: What we are suggesting here is that both the solvency audits and quality audits be streamlined; so currently if a medical group is

contracting with many, many health plans, through the Department of Corporations regulation of a health plan, there are a lot of -- data collection requirements are imposed on the health plans to get any information provided from the medical groups; so there's a lot of burden placed on the medical groups and so the idea is that we would eliminate that redundancy by allowing a medical group to request that the Department of Corporations or the regulatory authority identify organizations that could provide the audit in either case and that audit would be conducted and then sufficient for all the health plans for the purposes of the regulatory review.

MR. ROMERO: Thank you, Sara. Just one final point I neglected to mention. I'm not a fan of more government or larger government. In fact, I've run several exercises for the governor that have attempted to do just the opposite. The fundamental reason why I've been persuaded for some level of consolidation, I alluded to before but I want to hit this on the head more squarely. That is, fundamentally that if you have multiple regulators in any inconsistency of philosophy among those regulators, one regulator can encourage an innovation that another regulator stifles.

Furthermore, as new products are developed, the -- as new products are developed, they are outracing the definitions that causes to create the current regulatory structure in the first place; so my

fundamental argument for consolidation was to give a single regulator flexibility to adapt to and encourage innovation in the marketplace. And that's it.

DR. ENTHOVEN: Nancy?

MS. FARBER: I've got a question about your intent. As to the security side of the managed care industry, would the Department of Corporations retain control over that would, or would this new agency address both the securities issues and the health plan?

MR. ROMERO: Do you mean specifically, you know, when a plan floats equity just like any other manufacturer? No. That would be transferred to the securities regulator and specifically we recommend a new a department formed in July of this year called the Department of Financial Institutions; so if it's a straight securities function where the regulators don't really care what you make, whether it's wiggeds or health care, that should be done by securities regulators.

MS. FARBER: I'm just curious about the dividing line issues.

DR. ENTHOVEN: Well, that's a dividing line that we generally have with industry in general. If they're issuing securities to the public, then that activity goes under the securities regulator but the rest of their activities stay under their appropriate regulatory department.

MS. FARBER: With the Department of

Corporations, under this scenario retain any control whatsoever?

DR. ENTHOVEN: Only solvencies for IPO's. Oh, sorry. OSHO would deal with solvency, not DOC.

MS. FARBER: So everything would go to this regulator?

DR. ENTHOVEN: Except issues of stocks and bonds to the issue of securities to the public.

DR. SPURLOCK: Can I propose a question? We're going to talk general common for a portion of time and then we're going to take each one of the recommendations?

DR. ENTHOVEN: Right. I think we need to air the overall idea first, and then we'll walk through it.

Gallegos and then Rogers then Williams.

HON. GALLEGOS: Thank you, Alain. I just wanted to share with the Task Force some of the thought processes, in my mind. As you know Phil mentioned, I've recommended that we consider at least a five-member board that are determined by the Task Force members simply because I think -- and I agree with the consolidation concepts and all that, but I don't think we're going to find a single individual quite frankly who's going to be qualified to take on all these new duties.

You know, we're currently now with an oversight body that has one person, and I think a lot of

questions have been raised about the ability of that department to be able to oversee properly the managed care system; so I think that by bringing five people together, having them all appointed, and having the chairman of the board appointed as a full-time person, such as we have currently with the Air Resources Board or the Waste Management Board, and several other boards in the state, and having input from four other individuals who represent the different elements in the market, we're going to be able to have a better opportunity for getting input from all sides. When it comes to the decision making, if we give this board decision-making authority as opposed to advisory capacity only, then I think we're going to have a better oversight system. That's my opinion, any way, if we go that way with the board, however many members we decide to have. And there is accountability because these board members will be appointed to staggered terms and they're going to be appointed, you know, by the governor and if the chair or one of them isn't do a good job, you know, they're bounced after their terms, and as long as they're provided in writing the cause that they're terminated for -- did I fail to mention that? They can only be terminated in writing within, though. That's not true. I'm only joking.

DR. ENTHOVEN: Tony Rogers?

MR. RODGERS: Is it your intent also to have this organization position with HCFA and other

federal agencies, regulatory agencies, in lieu of what's happening now? In other words, taking over that responsibility. Because you have contractual issues in DHS that relate to HCFA, but then you have oversight and regulatory issues that HCFA's coming out that are delegated down to the states, et cetera.

MR. ROMERO: The purchasing portion of the contractual issue would say DHS. I'm not too familiar with what the other boards are saying. I can only guess that the answer would be yes.

DR. ENTHOVEN: The state regulation of Medicare risk contracts and state's component would be with the new department.

MS. SINGER: We also have -- the recommendation No. 7 sort of speaks to that. We've talked about eliminating interdepartmental redundancy, where possible.

MS. FARBER: Would that include the DHS oversight as well for the Medi-Cal population? I'm assuming not, but you're language is very broad, and there is some overlapping between DOC and DHS with regard to quality review.

DR. ENTHOVEN: And why Tony is doing it is that you have regulatory agency that has general regulatory oversight over the relationships that are established in the market, that they're appropriate, et cetera, within the framework that you're establishing here. Then you have contractual oversight. We contract

with DHS, purchasers contract with health plans. There's level of oversight. I see that staying with DHS, but the general industry oversight/relationship --

MR. ROMERO: Let me be clearer. I have a little trouble understanding your question. My view personally -- and I think this is in the paper. It may be a new thought -- is that there's going to be fundamental conflicts of interest if you try to have the same organization, both be a purchaser and be a regulator, and I think it's important to separate those and since DHS is the logical place for the purchasing to remain; therefore, the rest of it should -- the other half should go to this new organization.

MS. DECKER: I want to intrude one more time and just say it's been 15 minutes.

DR. ENTHOVEN: Okay. Thank you. Ron Williams?

MS. FARBER: Can I just follow up on that question though with regard to DHS? It seems that their function isn't just as a purchaser, but some of it is in oversight and enforcement on general standards. So what about that?

DR. ENTHOVEN: That's pushed downstream. We have some suggestions someplace that -- first thing to do is --

MS. SINGER: I can point it out. It's in recommendation No. 7. What we've tried to do is to say that with regard to the scope of issues covered by the

audit, they should not be duplicated. That leaves, where they're checking on different things that they would each do their own thing.

MS. O'SULLIVAN: Are those things this in DHS then or OSHO?

MS. SKUBIK: To the extent that they could be consolidated over to OSHO by would be, but DHS would continue to have, as Anthony Rodgers said a while ago, the need to oversee their contractual obligations.

MR. ROMERO: As a purchaser.

MS. SKUBIK: As a purchaser. To separate purchasing and health care quality oversight.

DR. ENTHOVEN: Okay. Williams?

MR. WILLIAMS: At this point I'd like to comment on the issue of consolidation and I have some questions and some comments. The first comment really goes back to the choice of the marketplace and this is one where some degree of argument is against my own self-interest because I think one of the implications of consolidation is that there will be fewer PPO's in California. And part of that is that there is a fundamental difference between an HMO plan, which is arranging for the delivery of care, and a PPO plan, which is operating under the Department of Insurance and is essentially a financial intermediary where what they've committed to do is a promise to pay and to reimburse with some minimal network activity.

We've already seen certain carriers

withdraw from the market here in California, and I think this will result in fewer participants. Part of the question I have is by combining the two, do we end up implicitly converting PPO's into HMO's so that you end up with less choice in the marketplace for consumers at the end of the day?

MR. ROMERO: Can I ask just a followup question, Ron, so I understand your question? Could you just elaborate a bit on why you feel that having the same regulator oversee PPO's and HMO's would end up reducing PPO's market share?

MR. WILLIAMS: Part of the issue is the very fundamentally different perspectives that when we have a new product or a new service area within the Department of Corporations, there's an enormous focus on the network accessibility standards, arranging for care, who's in the network, do you have the speciality and the subspeciality arrangements documented and defined? There are arrangements that tend to be contractual arrangements between the health plan and large medical group entities.

When you go to a -- typically a traditional PPO product, you have individual contracts between the physicians and the insurance entity, and the network is composed at a much higher level because the out-of-network flexibility that the member has is enormous. The member can essentially choose to go see any licensed physician in California as their own point

of choosing. So they're just two fundamentally different products.

The Department of Insurance, in my experience, is very concerned about solvency as a very important issue in a different way than the Department of Corporations is concerned about solvency. I think what we'll end up doing is having a good intention of creating kind of a level playing field, and to do that, we'll make everything look alike so that it fits the playing field that we're trying to consolidate it to.

We're under both. We operate under both. We have no bias one way or the other. We can comply with whatever the requirements are.

DR. ENTHOVEN: Ron, part of the sense of this would be to say is to create the Office of Health System Oversight would take over the DOC programs and then to say within two years the governor and legislature could consider folding in the DFO -- we don't favor -- I mean for one reason, we just think there's so much work to be done to get the Knox-Keene regulation straightened out, to get that department in place and so forth. Let's not burden them with this other issue, and we're proposing to just push that ahead for a couple of years and see -- to make sure first if they digest this first meal and are doing a good job and showing they can handle it, and then there would a good faith over the issues that you've raised, and you've raised some reasonable ones.

MR. ROMERO: Just a quick comment. Ron has raised an example of a really fundamental threshold issue about this whole recommendation. I made an argument earlier just a few moments ago, in essence, that consolidation of regulation of like substitutes would facilitate if the evolution of the industry in the innovation of new products.

You have made argument in this example which is the opposite of that, where, in essence, that would create one size fits all, drive us to a single market model. That diversity is a strain. This is a fundamental philosophical issue, but I just want to make that clear that that's one of the things you'll be deciding on in deciding these recommendations.

DR. ENTHOVEN: We have Zatkin, Shapiro, Rodriguez-Trias, Gilbert and Bowne, and then I would like us to start working through the recommendations, breaking this down through the recommendations.

Steve?

MR. ZATKIN: Just a few observations. It does make sense to heighten the level of competence at the top by establishing a new entity with a designated leader. I guess I disagree with a view that that kind of leadership can't be found in a single individual. I think that a number of state agencies which have very significant and substantial responsibilities are headed by a single individual. The Department of Health Services would be an example. I do believe that

accountability is greater and professionalism through establishing a single individual as a leader.

I think that it is very important, the task that we're doing, which is to identify the areas where there can be improvement in managed care and establishing both regulatory and private sector suggestions for those improvements is a very important task, and I think we're doing by and large a very good job.

My concern about the board approach, and I do respect the proposal and recognize that there are examples of that, my concern is that in establishing the improvements and the accountabilities, that we try to create an environment in which the department can function in a professional, accountable way and I'm afraid that we will have -- if I could use the term "excessive politicization" with the board. Now, maybe my fears are overstated, but that's sort of where I come down on this particular issue. I think it's important to regain public confidence. I think establishing a new agency with a high-level, visible leader is the right thing to do.

I do believe that there's a lot of quality people in the Department of Corporations Health Care Service Plan division and if a new agency is established that those people will be very much involved, but the key issue is the leadership. I think that single leader, accountable leader, appointed by the

administration is the way to go, whether it's a Democratic administration or Republican administration.

DR. ENTHOVEN: All right. Thank you.

Mr. Shapiro?

MR. SHAPIRO: Two points. The first point I to make is what you call this new entity is very important in terms of public recognition, and if we go aboard, for example, and recommend health, management oversight, nobody heard of DOC. No one is heard of OSHO, or whatever this is called; and if you want people to stop by the Department of Insurance or Marjorie's office or something when they have a problem, you have to give them something that they can relate to; so whether it's a board or an individual, I think what you call it is important.

With regard to the point Steve just made, I want not so much to endorse the Gallegos proposal but indicate why I believe the agency single director as a general matter a is problem. I have a chair next to me that's vacant. I've been sitting mostly next to Keith Bishop for a long time in these proceedings. There is no one currently in charge in this state of leadership on managed care. He had -- the paper called it "an abrupt resignation after only 16 months," which followed another very short-term proceeding of his predecessor, Mendoza.

There's going to be a lame duck appointed soon who's going to be gone in less than a year under a

single director. Dr. Petrocelin in San Diego said you don't have continuity. You don't have stability with a single director, assuming you could get a qualified person. Now, in terms of political influence, if you took at an analogy, which I call the Garemendy/Quackenbush Ship, the insurance industry went through a traumatic change in regulation by virtue of political change in leadership. And you have that even when you go through a Democratic/Republican, Republican/Democratic gubernatorial change.

I was appointed by a past Governor. I'm the kind of person who gets appointed. I'm going to put the fear factor in here. I meet the qualifications of this paper, and those are the kinds of people who can demand an allegiance of the governor and get in there, who are then in that process. If you have staggered terms, you have stability, you're going to have the governors' people in charge. They're going to have majority control, but you're not going to have the long periods of nobody in charge of instability and sudden and dramatic changes in administration.

Now, I have worked in traditions, and in commissions, you can do the same.

DR. ENTHOVEN: Thank you.

Rodriguez-Trias?

DR. RODRIGUEZ-TRIAS: I don't quite understand the structure; so I need some explanation. I've seen new agencies come and go, and I think their

effectiveness, to me, is predicated on several factors, but one key factor is who is under them who does the work and how institutionalized are those structures? So if you could explain to me whether this is going to subsume the part of the DOC that's now involved in the part --

MR. ROMERO: That would be somewhere between, you know, 50 and 95 percent of the staff would be in health care service plans in relation to DOC.

DR. RODRIGUEZ-TRIAS: Then maybe we need to be more explicit on that because it wasn't clear to me at all.

MR. ROMERO: Actually, just to be very clear about this, what I just said is people and presumably the lower level internal organizations, you folks have to decide whether we create a new organization from OSHO or DHMO and transfer it to them or whether you leave them at DOC, transfer out security regulation and then rename it.

DR. RODRIGUEZ-TRIAS: Well, the second question had to do with relationships with the State Health Department because I think we understatement the expertise that is in the Health Department in terms of the public health approach and being able to gather population-wide type information that I think is essential. That's among others, is that they have played their surveillance role in terms of quality of care in many areas for many years, and I think it's very

important to ensure that those streams of expertise are present in the structure.

MR. ROMERO: I agree.

MS. DECKER: Time check: It's a half an hour.

DR. ENTHOVEN: Gilbert?

DR. GILBERT: Very quickly on two points and kind of, Alain, to your point and Jeanie and Maryann. On the DHS, the relationship of the purchaser, the split I see is where the purchaser has special issues of requirements, culture, language, issues of social services. They would be responsible contractually around those issues. Where there are issues in common, quality management, overall quality management, financial solvency, I face four quality odds in the next two months. Three from DHS, you know, from DOC. I mean that, to me, they're all looking at the quality management process; so I think that, to me, is kind of a split since there's no special requirements.

Second, the one point that nobody's mentioned on the board versus a single-appointed person; although I agreed with both sides on some of the issues is the public nature. When you a board, the ability for the public to be out there and, to me, that will help with credibility. One of the issues of credibility now is the ability for the public to feel it is any avenue to go to the regulatory agency and at least state their case and deliver that case.

I think as we're thinking about the two different options, we have to think about the public accountability because ultimately that will come down to the credibility and I think under a board, you know, there's more public accountability.

DR. ENTHOVEN: Bowne?

MS. BOWNE: Very quickly. Being one of the few remaining kind of non-HMO, non-Knox-Keene companies that haven't yet completely left the state, we are under the Department of Insurance. It is very, very different than Knox-Keene. It's a very separate piece of regulation. The health business for companies like ours, Thyme Fordus, John Alden, and some others, it's a component of many other business that are regulated under the life -- and licensed under life insurance, in fact, the Department of Insurance. And so I would urge considerably a more careful looking at this, and then main rationale is that I think that in some things there's no question where we need to come under similar kinds of rules of the game because particularly in the consumer protections and that kind of thing, but there are all kinds of other things that it just doesn't match. I think it needs a little more than two years to get the one going and understanding what are the pluses and what needs to happen.

DR. ENTHOVEN: Okay. Alpert?

DR. ALPERT: I'd actually like to speak to the board versus single-person leadership. I think the

Gallegos Proposal actually includes both. It's clearly a board -- the advantages that Brad brought up about public accountability are immense, and I speak from sitting on a public board, it does that.

The way he's written this, the chair of this board is a full-time appointee. That's different than the way some boards work. It incorporates much more of the Steve Zatkin Approach. It has a person who is identified as a chair who is full time who will have the spotlight on them much more than a board that has a rotating chair or president. And the advantages of, however, of making these other five or however many people are in a decision-making board versus advisory, which is really a much more powerful position to get those people's input also being governor appointees, I think, brings the best of the both words. I don't think this is excluding the benefits of a single-person monopoly. I think it includes a lot; so I support this.

DR. ENTHOVEN: Michael Karpf?

DR. KARPF: As being written as an individual being responsible for running a large provider, to me, there's real value of being able to deal with one organization and get some expertise and can set standards. I think it would simplify the process quite a bit; so I'm in favor a single organization whether it's a board or an individual. I think that's a matter of debate. I also think that where you're in the process of putting together

recommendations that that will develop a number of bodies that will study issues, not Task Force, other kinds of groups that will also need a client; and I think that this board is a logical client for many of those groups that we suggest be brought together to study very particular issues that can be a consolidating principle in terms of us understanding how we go forward in not only improving managed health care but evaluating it over time, health care in general, evaluating it over time.

DR. ENTHOVEN: Thank you. I put myself on the list at this point. If I can just offer a few thoughts. As I've watched this thing, I didn't know much about the DOC when we got started in this Task Force except for occasional meetings with Gary Mendoza, where I was trying to give him a crash course in basic Health/Ecom I, and it did strike me from early on, and by the way, no negative personal remark, I think that both Mendoza and Bishop are very capable people, very nice people, quick learners, but I suppose this comes from the perspective of somebody who spent about 28 years trying to understand the health care industry and I'm still is not sure that I do, that it just seems somehow absurd and inappropriate to have this department headed by a securities lawyer with all the style that goes with it instead of somebody who's a seasoned health, professional health administrator, somebody who really understand the culture. In particular, I have

just seen many opportunities wasted by DOC where things could have been done in such a way as to run the whole thing more smoothly and more effectively, like the streamlining things that Sara was talking about.

Here we have kind an impasse, an unsatisfactory situation on the financial audits. The medical groups are supposed to be regulated for financial solvency by the health plans. Well, the Palo Alto clinic does not want to give their balance sheet Poly Casson because they know that if he sees it's got any money it, he'll want to negotiate it away. So, you know, a reason thing to do would be what we proposed here, as to -- this is crazy. Then we have -- I totally sympathize with the doctors and the medical groups and the IPA's. We've got an endless parade of people coming through here.

Now, I think if we had kind of a good, smart, strategic leader -- let me just say for you, by the way, for those of you who don't know about my checkered background, I spent eight years as one of the top leadership groups of the Department of Defense, which was even a more larger and more complicated task; so I do have substantial experience in public management.

It just seems to me this cries out for somebody who is a strong, effective strategic leader who can lay out a sense of direction and talk it out with team members of the legislature and governor and say,

"This is where we need to go." One of our main initiatives needs to streamline ito, to simplify it. Let's convene the role of the parties here in the private public sector. Get them together in a meeting and say, "How are we going to get to the desirable situation that there is one financial audit per year?" or however a period it is that we need, and we've laid out here a recommended way that you get to that.

I just think it's deplorable and appalling that it's taken all this time and that we still aren't even close to there. Now, PBGH has taken some excellent initiatives, but why wasn't DOC in there helping it? Because I think they did not have a leader who understood where this ought to go.

Take the quality audits. Again, we have all these different auditing entities and so forth duplicating -- everybody does a less-than-vast job of it so that the doctors understandably complain they've got parades of inspectors and so forth. The leader of the Department of Health Services oversight ought to convoke the leaders of the health plans, get some big ones and some small ones so other health professionals, appropriately credentialed and qualified and so forth, can sit down and say, "Now, the answer is we're going to simplify this and streamline it. Now let's talk about how we get to that answer," and again, with credentialing, with the disclosure, and just a lot of things where I think we need to have a kind of strategic

leader who can see these problems coming.

Anybody with some ears, with sensitivity, would have seen coming the problem of continuity when U.C. Davis and the Foundation Health Plan had a split and left 14,000 PERS beneficiaries high and dry; so poor Margaret Stanley had to take a full-page add in the paper to say will you guys please -- well, I think we need somebody with eyes and ears and sensitivity to try to move the industry in the direction it ought to be moving and would see that problem coming and call in the health plans and say, "Look guys. Here is the real problem the public is concerned about and their right to be concerned about it. I'm giving you a chance to fix it yourselves. I just assume not to have ask for legislation. I'd love to see you do it; so do it or else I'll have to talk to my friends on the legislature about it."

You need a health professional, somebody with a compassionate face. I was horrified at some of the letters people got who don't end the case of the child who by died by saying, "I find no violation of Knox-Keene law here," but something who would write empathetically as a health professional, et cetera; and I think that requires leadership.

I'm very skeptical of the idea of the five-person board because then it's like "I decided to consolidate audits by a 2 to 3 vote."

So Les, Tony, Diane, and then J. D.

DR. KARPF: Could I ask a question?

DR. ENTHOVEN: Yeah.

DR. KARPF: Could we define for ourselves whether we're now talking about leadership approach or whether we're talking about the concept of a new entity? If we've assumed that there's a new entity, then the discussion moves on leadership. Can we just have another straw vote?

DR. ENTHOVEN: We're just kind of on the edge here deciding whether either to have lunch or start going to the individuals. Let's take the people who have got their hands up. We've got a list of hands up, and then I would like to move us then to specific recommendations.

Ms. Berte?

MS. BERTE: Yes. Mr Chairman, I would like to address the subject of board (unintelligble) the single individual as the chief regulator and not taking a position for or against this proposal. I just think historically there is a different role for boards that have been utilized by the legislature then what you are discussing here.

Historically a board like the Medical Board was established because you needed the group of physicians to determine what the standards were, the vocational professional standards, for admitting people into a practice. Most of the boards were established to regulate over professions or locations where you had

individual practitioners that meet a set of educational experience and testing standards in order to be committed to practice in non-licensure laws or private restraining laws. You're not permitted to practice unless you have a received a license from the state. So that's the historical role, which is why you have on the medical board a majority physicians who are the actually licensees of the board.

When you look at the rest of the boards and the department -- and we have 27 of them. We used to have 32. The legislature has just eliminated a few of them in the last couple years and turned them into boroughs under direct authority of a single regulator -- there is a very, very uneven history to some of those.

The horrors of screaming about the Cemetery Board, the Funeral Board, over a number of years and most recently we're now taking over the private post-secondary vocational education from a counsel on January 1 because of the nonstop complaining that has gone on for many years about the effectiveness. In 1991 --

MS. BOWNE: Meaning effective or not effective?

MS. BERTE: Not effective. Thank you. The state auditor did a review of the Medical Board in '91 found that the average time it took them to respond to a complaint then was 245 days, and of course what

you've seen is even with a great board, there can be times when who's on it, the motivation of those folks, the executive director or whoever it is, appointed by that board may or may not be as responsive as you want them to be. So I think you just need to look that.

The legislature themselves expressed a great deal of concern about boards. All of them are under a sunset review process that's been going on for the last three years; so I just think you need to look at that.

The appointees on boards are term appointments so you don't necessarily have the same level of accountability that you have with someone like me. The governor's office gets a hundred letters complaining that we're not following up on complaints. I'm gone in one day if I'm not serving a displeasure; so I think you have to weigh those two different things in both who's on the board, and the statutes are generally very prescriptive about the patterns for these people, for most of licensure boards and these licensees. I don't know that you would want the health plans to dominate membership on the regulatory board. That's one of the great conflicts and criticisms inherent in those kinds of licensure boards.

One of the things I think that we see also is that the full-time executive officer, executive director, spends about half their time satisfying the board and doing board relations rather than running the

agency. I think that's one of the struggles that they are in.

The speed of decision making: Most of the boards meet quarterly. The Medical Board meets more often, may or may not be as quick. I don't agree that the process is any more open. We do all of our of regulations under the Administrative Procedures Act advisory. Instead of having an industry dominate the decision-making process, and they certainly have plenty of access to that decision-making process, the industry takes on an advisory role; so I think those are just a couple of the things you'd want to look at in deciding whether it's a direct commissioner or a board structure.

Consumer groups have, with very few exceptions been very critical of our regulatory boards. They advocate a hundred percent public membership on those boards. The Wilk Administrations advocates public member majority on all boards for the very same reason that term of conflict between who controls the regulator and the outcomes exist.

If you have public membership on a board, then it doesn't have necessarily the expertise that you're trying to get by finding who's on it that has expertise; so you're still going to get it in an advisory way. It will come to the regulator in regulatory hearings in all of the forms that I mentioned. In your weighing of those two options, and this is kind of a hybrid, that there are -- the history

in practice has not necessarily been what I think is the ideal situation in both cases because you can have a very weak commissioner of record at one.

DR. ENTHOVEN: Thank you. Les Schlaegel. I have a list now of Schlaegel, Rodgers, Northway, Griffith, Spurlock, Werdegar.

MR. SCHLAEGEL: I agree a lot with what I just heard. I do agree that you -- my personal belief is you need an individual out there, someone like me who can throw their name around because that's how I start addressing issues, "So and so is responsible for this, and if it isn't happening right now -- I do it with the Department of Corporations and it just doesn't quite work well if I don't have an individual's name.

I also know that you can have lots of divisions, and I think picking up on Ron Williams' statement, I think that he's stating where we're trying to regulate probably are different animals. We're going to end up probably with divisions within the department and those folks will add expertise to that head of the department, who should be out there advising the governor and the legislature.

I'm wondering, based upon you comment, Marjorie, if we should be doing a -- suggesting legislation adopting an official advisory board to that individual rather than just if they happen to develop an advisory board.

MS. BERTE: We found advisory boards to be

very conservative in response to your question, and we used them greatly. In fact, we have a broader base of input. We have an advisory committee now for the barbering and cosmetology industry, which is a half a million licensed people in this state that has 36 people because there are 11 different license departments and now they all feel they have better input access and reaction from the regulators than they ever had with a five-person board.

I really think it all goes back to the quality of the appointments. It doesn't matter whether the board -- the Medical Board had changed dramatically over the last 5 or 6 years. The people that have been appointed on the executive legislation --

MR. SCHLAEGEL: And during lunch, I would like to talk to Michael because I don't understand why we've gone 15 months or so --

MR. SHAPIRO: Unless if you look at Gallegos's Proposal very broadly, there is such advisory commissioners. There's a glaring omission in the paper that doesn't even reference it. We've never heard from it. It's a useless advisory effort in terms of process; so we've been there.

DR. ENTHOVEN: Okay. Les, is that it? Thank you very much.

Mr. Rogers?

MR. ROGERS: Just some observation from having worked in the public sector. One of the problems

that any executive would have in this particular area is that if you have this entity under the state employment rules, procurement rules, you are immediately handicapping people and that's just the nature of government.

We operate under an authority as a local initiative, and I have found that to be much more flexible in terms of my ability to hire the expertise I need and not be required to pick up other people's problems that are transferred to you just by the nature of civil service, et cetera, procurement.

This particular agency is going to have to have three things that it didn't have. One is the ability to get technology when it needs it. Number 2 is the ability to hire expertise and capability because it's going to change. Our industry changes too rapidly -- you have to have expertise --and the ability to upgrade not only their people but their systems over time, and government has a real problem doing that.

I'd also like if we talked about the leadership is what tools we will give this agency that will allow it to prove to be effective over time.

DR. ENTHOVEN: Good. Northway?

DR. NORTHWAY: One of the things that just sitting here and listening to a lot of you talking, know a lot more about this than I do. Now, I'm not -- I'm talking against heading in some new group. I'm not sure that we will have ended up by consolidating anything.

We will have moved a function from a dysfunctional entity into a new entity. We'll still have the Department of Health. We'll still have the Department of Corporations, in which some people have to report to. We'll still have an insurance agency. We'll still have Consumer Affairs.

Maybe, and I read through this and everything says "should, should, should," we may be to reduce the number of audits. I think I'd like to have somebody talking about what the real consolidation is going to be or is this going to be another agency which we hope will do the kind of things Alain and J.D. would like to see it?

MR. ROMERO: Let me respond to at least part of your question. You're right. It's consolidation and interpreted to mean shrinking the number of boxes at the ORG chart. It is either neutral or anti-consolidation, depending upon how it's implemented. What I meant by consolidation was consolidation of the regulation, the regulation of certain segments of the health care industry that's currently scattered among several organizations into a single organization.

Now, is that sufficient clarification or do you have further questions?

MR. NORTHWAY: Well, maybe I didn't quite get it. What I really heard you say is take the kind of things that the DOC does not do very well for managed

care plans and move them into this new organization will do it better, but they will still have the same relation. The providers, in fact, particularly hospital providers, may still in fact have to deal with the same number of have agencies that we deal with now. Maybe I'm missing it. Apparently I am.

MR. ROMERO: If I can refer you, J.D., to page 2, the second page 2, in the paper itself, not the findings and recommendations section. It's a figure called "overview of regulatory structure," and I just want to point out the line in about the middle of the spectrum from HMO on one end and the fee for service on the end.

The consolidation I'm referring to, in essence, is consolidation of -- what we have now, as is pointed out in the two little boxes, DOC and DOI, is we've got these different kinds of products regulated across several different regulators. In essence, consolidating the regulation of these different products, in particular those in the middling that are currently unregulated in a single place.

MR. NORTHWAY: And then somewhere, I think, we're going to deal with the issue that Ron brought up that if that happens, in fact, some of these other products may disappear; so we may have solved one problem, but created a new one.

MR. ROMERO: As I said, it's a fundamental philosophical issue. Do you believe that will encourage

innovation by allowing all like products to have -- or substitute products to be subjected to the same standards, or do you believe that it will be one-size-fits-all that will crab most products except for one type out of a market? I mean I have a view, but you will all have your own views.

DR. ENTHOVEN: Another part of it, D.J., is there's one line which I think is important. It says "The state should give OSHO authority to facilitate the existing oversight of medical groups, IPA's, other entities and risk contracts," and so forth; so the idea would be you would have the authority and presumably the responsibility to be charged with, you know, get out there, bring all these parties together, and simplify it. Perhaps, you know, acting as the governor's lead agency on doing this with some leverage over the others to get them on board so that we agree on one audit standard, for example.

Okay. Let's see. Griffiths?

MS. GRIFFITHS: I have two points to make. One and following up on what Marjorie said concerning why multi-member boards and commissions were eliminated. I think it's an accurate portrayal in some cases but not in all. I think that, concerning the point of whether it's pro consumer to eliminate many consumer group's support, elimination of boards, commissions. I think it's a mixed record. In some cases, consumer groups have supported that and others not.

I think the most recent counsel that was eliminated, the one regulating the trade schools in fact, was an effort that was largely supported and pressed not by consumer groups but by the regulated industry, and that was the reason why; so my view about boards and commissions, and I have worked and staffed one, is that sometimes they work and sometimes they don't.

That kind of is a natural segue to my other point which is to follow up with the chairman's, I think, appropriately his impassioned speech about the need for someone who had some background to fill these positions. While I support that view, I think that that point doesn't cut toward either the executive director's recommendation or Assemblyman Gallegos's recommendation.

Whether you have a single-appointed official appointed by the governor under the agency or whether you have a multi-measure board with a split-appointing authority, the appointees are as good as the governor or the legislative leadership that appoints them. We certainly have a history of both Republican and Democratic administrations gubernatorially here of political clonies being appointed to run agencies, ones who have absolutely no background in the field, and I don't think that this language that's written here would have that much of an affect on that type of an appointment process.

Although I support your view, I think

that's an argument at best made to the legislative leadership, if it's a split authority or if it's a united authority to the governor that the quality of the appointments for an entity as important as this should be better than one might have thought they were in the past.

DR. ENTHOVEN: We try to get the language, Diane, about the head of OSHO should be as described above, "A person of stature in the health service industry who demand respect and exercise strategic leadership."

MS. GRIFFITHS: It's in the eye of the beholder. I don't know, Alain, would think -- would probably think that would mean someone who had worked in the health service industry. As Michael points out, I think that from the Senate's point of view, if you were confirming someone, either Michael or I would be qualified to hold that position and you might not think that we were a person of stature in the health service history, but the legislature might.

DR. ENTHOVEN: Well, what do we do about those people?

Dr. Spurlock?

DR. SPURLOCK: Thank you, Mr. Chairman. I'm going to just give my views on the leadership issue since I thought we were going to go point by point, but I think there is enough discussion in the session that I might do it now, and I think it's more appropriate now.

I am to the core a generalist, and I think that the concept of an appointed head with an advisory body rather than a board is more appealing for a couple of reasons, and the construct that I've used is really a medical construct and I'm going to give an example of how I do things from a medical perspective.

As a generalist, my job primarily is to synthesize information, to know a huge variety of things but to be expert in nothing and to be able to synthesize diverse areas and to make decisions. Where that becomes an example of how that works in the board versus the appointed head model is in the intensive care unit when patients are seriously ill.

In most cases patients have a team. There are very few patients that have only one physician that care for them in the intensive care unit. It's a team approach. You can say it's analogous to the board approach and in the vast majority of times, it works very, very nicely and patients can get care.

If you look at the times when it breaks down, and this is the issue that I have, is when it breaks down and why does it break down? It's usually because it was absent the person who makes it necessary to synthesize all the processes. Because this -- when it breaks down from the patients and the families and the clinical perspective is because the cardiologist and the pulmonologist couldn't agree and there was nobody to sort of be arbitrating to synthesize the information and

speak on behalf of the patient's best interest.

I really think that there's great risk for the board to be able to do that, that when you have multiple perspectives on there, that you can't synthesize the information appropriately to make the best decision for what's good for all the consumers.

The final point on that issue would be in the intensive care unit, we usually bring in the appropriate perspectives. I'm not sure that you could limit a board, and this Task Force is a good example of how we're absent perspectives here, and it's been mentioned numerous times that there was no person representing the nursing perspective on this Task Force. I just can't conceive 5 or 7 or 25 being enough perspectives in this diverse industry to be able to put into a board.

I think what that really cries out for is the synthesis of those of those perspectives in one person to be accountable and they have the advisory component, like you do in the intensive care unit, and the advisory board may actually make most of the important recommendations as it does in intensive care units, where the appointed head sits back, and like I do as a generalist, go by their decisions. But when there's conflict or when there needs to be something to keep the system from breaking down, I think you need that synthesis.

DR. ENTHOVEN: Let's now turn to

recommendations, page 3, recommendation 1.

MS. DECKER: It's been one hour.

DR. ENTHOVEN: We'll break for lunch, then.

MR. KARPF: Can't we take a straw vote on 1 just to see if there's consensus?

DR. ENTHOVEN: On 1-A?

DR. KARPF: All right. Let's take a straw vote on 1-A. "The governor and legislature could create a new office of health systems oversight" -- you can all read it there.

DR. KARPF: Not necessarily that name, but in context.

DR. ENTHOVEN: We'll have a contest for the name.

MR. ZATKIN: The first sentence of 1-A, not the second?

DR. ENTHOVEN: The first sentence of 1-A. All in favor?

Okay. We got it.

(Lunch recess.)

DR. ENTHOVEN: Page 3, first half of 1-A, new department. Now, second sentence. "All funds should be immediately transferred to the new OSHO." The thinking here was to get this department on its feet by focusing mainly on the work before it and straightening out all the internal processes and get the management of existing DOC. The idea with OPAD was that it's the

Office of Planning and Development. It could be involved in strategic planning and thinking, data gathering about the whole health care system, which could eliminate the work of the department. We probably ought to ask Dave Werdegar to comment on this.

DR. WERDEGAR: Well, the office is honored to be so recognized, truly. Although in 1-A, state government learns to be a little bit carry about one's department being transferred or consolidated. I would say as to this second part, which is kind of a parenthetic. I mean it is A, B, and C that is the most important, and the second sentence of A can be handled in a variety of ways.

I think the kind of services that our office can bring which relate to data, quality of care, evaluation, and planning quite initially be made available on -- which is commonly done -- interagency; that is, interdepartmental arrangements until we see fully how this entity is going to form. I was going to say, and maybe I can do it over lunch because people are eating and the time pressures are not felt as keenly, but last year in a program that the governor called California Competes that Romero was very much involved in, all agencies and throughout the government they looked at ways of streamlining and so forth, and within the Health and Welfare Agency there was a lot of very interesting discussion. It never -- it didn't go anywhere. There's no recommendations that ever went

forward. It would have to go to the legislature, and reorganizations are always energy consuming. You have to be sure you're not just rearranging deck chairs. But one of the interesting proposals in reorganization in the Health and Welfare Agency, was to make the department -- to separate the Medi-cal administration from the Department of Health and that appealed to a lot of people because it could then restore the Department of Public Health to really being the protector of public health, the evaluator of quality care. It would not be in conflict as a purchaser of health care services and have a separate entity, sort of like HCFA, administer the Medi-Cal program, and purchase services.

It may be that that would one day happen. It didn't happen last year, but in that kind of a scenario I must say, because I think the public at large has a sense that the Department of Health, the Department of Public Health, does stand for its mission of protecting and promoting the health of Californians. In that scenario, I could well have seen the functions of OSHO, or this office that we're creating, being in a Department of Health, but that's not to be at the moment.

The next thing I would mention over lunch which has been referred to by a number of people, and this is just the political science as it were of California state government and the effectiveness of various governance structures, several people had

described that commissions have a variable success record. In a number of instances it's felt that the commissions simply become the creatures of organizations there. They were originally to regulate. There is the issue of having multiple individuals trying to make decisions when, as Alain described, one needs a directive of strategic thinking.

In state government, the agencies -- and I'm not sure that everybody is aware of this -- but Health and Welfare Agency contains my department, Department of Health Services, and a variety of other departments. There are a dozen of them in all: Mental Health, Alcohol, Drug Abuse, and so on. There is within that whole agency a culture of looking at health and social services human needs. Quite separate from that -- and the agency head, the secretary, in this case, Secretary Foley is at cabinet level. Then you have another whole agency, which is business, transportation, I forget its full title -- commerce, and it's within that agency, which has no culture related to health care whatsoever, that you have a department which is the department on corporations, and so the head -- the commissioner of corporations is not even at cabinet level but is within an agency that has no culture. We've all talked about it and recognize that for historical purposes at one time it made sense to have Department of Corporations play a big role in managed care, and that 20 years ago when they would belly up

financially, but right now those aren't the principal interests.

The group has already decided and recognized to move the importance of moving this oversight function for managed care into some new home. I actually feel that to move it in the Health and Welfare Agency would not work because of the conflicts still within the Health and Welfare Agency there is Medi-Cal contracting and purchasing of services, and so the question is where to house it and its relationship to governor and legislature.

My own thoughts are between two possibilities. One is to create a brand new agency with the director of that agency at cabinet level and directing this enterprise that we're describing that will have oversight over managed care and other entities at risk. But short of creating a whole agency, the next best is to create an office, as Phil has described, where there is a director, a director appointed by the governor accountable to, and that person has to perform pretty well or the governor would be embarrassed, but it has the clout of direct access to the governor, and one builds a department and staff. Such an office -- and the Office of Emergency Services is one that reports directly to the governor -- can have and should have, as this entity might, an official advisory committee, but the advisory committee is advisory. It could be nicely balanced and the kind of balance or the sorts of balance

that one seeks could be described and set forth in our recommendations.

The director would have an opportunity to basically build a department with the capacities that are needed do this job. The department head could also draw another department, could draw on the talents of my department, with data, quality of care, and other capacities, can draw on the Department of Health Services with its staff of epidemiologists, with collection of morbidity and mortality data, and the interlinkage of those kind of data. I'm make basically sort of making a case for it, not at the moment, immediately transferring the Office of Statewide Health Planning, but more importantly supporting the government's advice that Phil Romero has laid out.

DR. ENTHOVEN: Okay. Thank you.

Steve Zatkin?

MR. ZATKIN: I think I'd like to second the point we just made about OSHPD because unless the intention is to move other health-related entities into the same department as the one we're creating, David's office serves all of those entities. It provides data on health planning data that is relevant to hospital services and to public health services, and so in the absence of a plan which is to move all this other stuff into the department, I'm not sure I see the rationale at this point.

DR. ENTHOVEN: Nancy Farber?

MS. FARBER: I agree. You have ask to ask OSHPD what else they're doing besides relating to this issue, and they have a very full plate. Just from the hospital standpoint, there are times when we wait for a while in a cue to get OSHPD's attention to take that and put it under a new agency with new leadership, and there are more all together things that OSHPD does for other health-care related issues which, I think, would be very difficult for hospitals.

DR. ENTHOVEN: I think the thought here that started down the road was to get this department up and going with the idea that it would be the eventual home for more of the system but to address each of those in time; first let the department prove itself, make sure it's got its own act in order and then look at what should come in next, DOI, regulation of hospitals; so eventually you would try to get the coordination of the whole regulation to the health care system --

MS. FARBER: All right. Just to give you an example. All the hospitals in the state California have to come up to a certain seismic standard by the year 2008. OSHPD is just now beginning to get a whole raft of seismic plans from hospitals requesting approval.

DR. ENTHOVEN: Let me ask, is that OSHPD or DHS?

MS. FARBER: OSHPD.

MR. ZATKIN: OSHPD. They have a hospital

focus and in the absence of a determination to move the hospital functions out of DHS into this new agency is putting the cart before the horse, I think, to designate OSHPD's move.

MS. FARBER: I think you're trying to be economical in borrowing their staff, but I don't think you would appreciate everything else they're doing.

MR. SCHLAEGEL: I'd like a clarification. Who now sets the agenda for what they're doing? It does now become an important issue for --

MR. ZATKIN: The legislature.

MR. SCHLAEGEL: Everything they have to produce comes from the legislature?

MR. ZATKIN: Well, that's their authorization to act, and the requirements to act are primarily legislative.

MR. SCHLAEGEL: My concern is that within that two-year period of time, a lot of investigation and research and data function needs to go on. If it's going to be bumped by other things that have already been established by the legislature, I would rather have that organization move over and be under the guidance of the new Office of Health or whatever they're calling it to get the data it needs.

DR. WERDEGAR: I think the easiest way of accomplishing that is if the office were established with a rigorous director, that director does have access to through inter-departmental arrangements. There may

be some exchange of resources, dollars, and so forth, but could really -- it's basically writing important contractual arrangements with our office for data, with Department of Health Services for their morbidity, mortality, and all sorts of etiological data. It could also, of course, write contracts with university entities and whatnot.

You certainly would want to give the leadership to the new office but be able to draw on the capacities throughout state government. I think and am truly honored I had no part in this.

DR. ENTHOVEN: Dave, thank you.

What I would like to do is call for a straw vote. Should we strike the second sentence of 1-A?

All in favor? So that is struck.

We now move to 1-B, "all entities that practice medicine should be regulated to the care they provide and impact the medical physicians" -- you can read it there.

Yes?

MS. BERTE: This says "any individual or entity practicing medicine." Does this imply that all of the medical licensing boards would be put into this OSHO?

DR. ENTHOVEN: I don't think that was the intent.

MS. BERTE: The way this was written, I

think it would say that.

MS. SINGER: No. The first sentence just speaks of the principle and the second sentence is in reference to the recommendations.

MR. ROMERO: If I can just elaborate. In the medical necessity paper there will be substantial discussion about the whole issue of practice of medicine, and I think this was mainly so as not to preempt that paper. This was in reference to whatever recommendations come out of that paper later.

MS. BERTE: You have to be careful with the term "practice medicine."

MR. ROMERO: And in that paper I'm well aware of that.

DR. WERDEGAR: If you struck the first sentence, would it still make sense?

MS. BERTE: It says, "other entities practicing medicine."

DR. WERDEGAR: No, but if you strike that then have "OSHO regulating medical groups, IPA's, and any other entities."

DR. ENTHOVEN: Maybe it needs to be "authorize" and "requirement". The thing is what's going to be needed is to do the streamlining functions that we talked about, is for OSHO to deal directly with medical groups, ICA's, and others efforts.

Yes? Bruce Spurlock then Terry Hartshorn.

MR. SPURLOCK: Thank you, Mr. Chairman. I

actually don't have a problem with the first sentence. It's the second sentence. I think there's some difficulty with in talking with physicians and medical groups and IPA's throughout the state on this particular issue in this particular line, this was where the great concern was on their part.

I want to say right up front that I think most of the medical groups and the ones that are certainly enlightened, in the IPA's and the leadership that I've talked to, completely agree with the idea that we need to have direct regulation of medical groups and IPA's. I don't think my issues were in the context of direct regulation.

I think it's the broad context of what that really means, and if you ask somebody if you mind to be regulated and they say, "Well, what does it depends on what you're talking with regulation"; so I had two sort of alternatives to sort of make that really clear that we're not just talking about direct regulation. The one option would be to delete it completely or the other option would be to say, "regulate directly medical groups and IPA's and other entities, dah-dah-dah," as described further in the recommendations because I think when we take about the specific types of regulation is where we can have more discussion of what needs to be broadened and what needs to be narrowed on this.

MR. ROMERO: Dr. Spurlock, I have a

question. So the reference to more detail that you just referred to --

DR. SPURLOCK: Right.

MR. ROMERO: -- that's not over which medical groups get regulated, but over the functions of -- the regulatory functions that get performed?

DR. SPURLOCK: Exactly. It's what regulatory functions are performed, and that's what most medical groups and IPA's are concerned about is that if you're going to start regulating things that are unnecessary or that are duplicative or whatever. And there may be ones that really make a lot of sense, and I think five and six actually go a long ways that Alain has talked about that make a lot of sense, but it's the concept of this open checkbook regulation concept that I think most groups have difficulty with.

I would just recommend that we specify what regulations are -- that we are going to specify further in the recommendations so that it's not just such a broad concept.

DR. ENTHOVEN: Thank you.

Zatkin?

MR. ZATKIN: I guess I agree with Bruce in concept, but I think it may be a little confusing in terms of how you approach it. I would prefer just eliminating the section and referring specifically to what's being done because I believe later on what's being done is recognizing the fact that the medical

groups are accountable through the health plans and that the problem has been that the health plans have difficulty, at least many of them do, unless it's a single relationship between the plan and the medical group, in accomplishing that function.

When you have multiple medical groups dealing with a plan or dealing with multiple plans and you have the kind of issues that were previously mentioned about the willingness to disclose information for contractual or competitive reasons and so on and what I believe is attempted in the balance of this document is to create an approach that would allow audits to occur in a way that is respectful of solving those other problems.

DR. ENTHOVEN: The intent was not to create a new, independent rule-making process that could sit there and start promulgating rules for --

DR. SPURLOCK: That's sort of what it accomplishes, but in will. Unless your specific about what you're trying to regulate, are reasonably specific.

MR. ZATKIN: Where you can get into confusion is that there are lots of medical groups that really are not functionally dealing with plans which means it's not managed care in that context, but focusing on what medical groups are doing in relation to managed care, and I think that's done in the balance of the document.

DR. SPURLOCK: Exactly.

DR. ENTHOVEN: Hartshorn?

MR. HARTSHORN: I'm going to speak against a few generalities, first, and I don't have any specific wording, but I do have a few specific comments.

I think I agree with what you said, Alain. that we might be starting on a path here where other things can pulled in in the future, but this new agency needs to kind of prove itself initially because we've got a lot of issues with just duplication, streamlining, and streamlining for the benefit of the consumer. I don't know if that's in here or not, but I want to make sure that that's part of it because we've got a lot of issues with the consumer that we have to deal with.

However, there's a lot of moving parts in health care today. We've got PSN's or PSO's where groups of doctors or health care systems can contract directly with Medicare. We've got, I'll call them other weird arrangements stringing up all the time and I think there needs to be a housing place for those where someone will take a look at it and say, "Is this organization arranging for care or are they providing care or are they insuring care?" Don't read anything more to that because where I'm looking is down the road because I agree with what Ron said earlier. If we're going to fold in PPO's, we need to do that very carefully because we don't want to reduce choice. You want to increase choice.

I can see that an agency that's going a good job, that we will fold things in later; so I guess one of my recommendations is we need to be specific so as to overly burden the medical groups, IPA's, the practitioners that are providing the directive care today, but also the flexibility that things are going to change in the future; so I would want to see a lot of rigid things put in that take an act of legislature and maybe even somebody with higher authority, God, to change because we don't want to get locked into something a little bit like we're locked into today where there's long delays, there's not proper oversight, and things like that.

DR. ENTHOVEN: Okay. Dr. Alpert?

DR. ALPERT: I see this 1-B from a totally perspective than what I've heard and maybe that's the problem. There may be some confusion about it. It might be where it is, whatever, and it's directly in response to what Bruce said. I think that's what stimulated Bruce to make his comments.

I'd say the first sentence here is essentially framing the issue of regulation about the care in medical practice, about the impact of medical decisions on a citizen of the state, about the impact of the care that is provided on a citizen and seeing -- and actually it says "all entities that practice medicine whether they be individuals or organizations to the extent that they can be shown to practice medicine,

should be regulated for that care in the impact of those medical decisions." And I reference that as a -- to me, this is simply catching up in society to what Californians started in 1876 with the Medical Practice Act, and they said essentially this, "for the practice of medicine," but at that point it was only individuals, and those individuals were then, by creation of the Medical Board, held accountable in terms of public regulation to these standards for those decision; and with the peridime shift that we've had, to me this -- actually I think that first sentence is visionary because what it says -- I think what it says is that no matter what entities, if we have changed who makes decisions, who gives care, if it's groups of people, if it's a hundred years from now the trans-cosmic, intergalactic health delivery system, then actually this would still apply.

The wording that was created in the Medical Board in 1876 doesn't apply anymore. It was visionary for 121 years, but now it's got a couple of things that have fallen out. There are some entities that probably can make decisions and have care given to people that really aren't accountable in the public sector because they don't have specific regulation, nobody say anywhere that they're regulated.

Then from the point of view of the DOC thing with 7,000 calls a month about care and one disciplinary action over the past decade with regard to

care, there's a sense that, well, maybe even though there were no regulations, the quality, the quality part, the part that impacts medical decisions wasn't being regulated.

I just see this as catching up with regard to how the citizens of the state have held accountable. We've got the public regulations, the delivery of care, I don't see it myself as dealing with the fiscal aspects with the business part, the parts at one time separating the business parts and so forth.

In that case maybe it should be discussed in the practice of medicine paper. That's why it's not there now, it's here. But here with all this talking about the solvency and the audits, I agree with everything everybody has said about the audits and the solvency and all of that stuff; so I don't think that's what this is trying to do.

MR. ROMERO: Just a very quick interjection just to underscore a subtext of those comments. I don't know how clear it is in this paper, but it certainly was my intention that this organization would fuse financial and quality audits in the same place. And that I -- and this is a personal view. I'm inclined to see that it's an increasingly false dichotomy to be in the same organizations.

DR. ENTHOVEN: Dr. J.D., Health Provider.

DR. NORTHWAY: Health Provider, yeah. Thank you. Maybe I should make a statement about what

happened yesterday. I was just talking about how my name was put in the minutes.

DR. ENTHOVEN: J.D., I'm just reaching for light sources of humor to keep the lecture --

DR. NORTHWAY: I'm wondering, as I listen to what Bruce says, that are we really asking this group to regulate? Are we really asking this group to review? When you're doing audits and this kind of thing is you're reviewing what their doing and presumably you've got to make recommendations or something to maybe the Consumers Affairs or whoever else is going to regulate it.

The thing that, I think, turns people off is you just say, "Oh, because I have to regulate it." But in fact I think what is interesting -- and maybe I'm putting the wrong words in your mouth and Bruce's -- and we want some oversight here for people to come in and review what these groups are doing and if they're doing something wrong, then make some recommendations or whatever. Maybe that gets into the regulation thing, I'm not sure. But I think where Bruce is coming from is to just say you're going to regulate them and come in and do whatever you want to do. I don't think we're interested in that.

We don't know what they're doing now because there's no real entity that reviews these groups to any great extent in terms of practice, I guess, or maybe there's so many that they don't get together. We

want to review what they do and then see if there's some reason to have additional regulations or more specific regulations because of the results of the reviews. Maybe I'm wrong in that regard. I don't know.

DR. ENTHOVEN: That could be not true on these consolidated quality audits; so maybe what you're saying is, "Let's get this audit process straightened out and done, and done well," and then somebody can take another look and say, "Yeah, there are some big problems that need to be" --

Yes?

MS. SINGER: If I can just maybe direct people to recommendation No. 3, which might accomplish the specifics of what it is that they're talking about that they want to do without going so far as to directly regulating because they're -- we're providing -- what we suggested was giving the authority to this new entity to facilitate the existing oversight of medical groups and then we can deal with the specific areas where we're contemplating.

DR. ALPERT: It doesn't say anything about the delivery of care. My only issue is that we've always held the delivery of care accountable as the state to the regulatory process in terms of medical decisions.

DR. ENTHOVEN: Zatkin?

MR. ZATKIN: Yeah. I think it's important to have a baseline understanding of what currently

occurs. Maybe we have a disagreement about that. My understanding of what currently occurs is if a group has a Knox-Keene -- I'm sorry. If a group has contract with a health plan that is part of the department's audit, the group's activities are reviewed because that's where the care is delivered and the department is responsible for reviewing care.

Now, I know that's what occurs in our organization, and I'm assuming it occurs in other health plans. The group is not licensed by the Department of Corporations, the health plan is; but in order to perform the function of reviewing the quality of care in the plans, you have to go to the groups, so I believe that delivery of care is reviewed. I think that's true of NCQA activities as well in the private sector. Now, there are groups there are not contracting with health plans and if the intention is to have review of those groups -- but that's not really managed care, I guess, and not in our purview; so I think that's the baseline, and maybe there's disagreement on that.

DR. ALPERT: Can I respond?

DR. ENTHOVEN: Sure.

DR. ALPERT: I don't know if I'm being understood. I'd be happy in the second sentence to strike "medical groups, IPA'S," and have it read, page 3, under B, second sentence, "to this end the governor and legislature to require OSHO to regulate any entities practicing medicines that are currently not regulated

directly by any other government oversight agency." In other words, the only reason -- all that does is it says any entity that evolves.

I'm trying to not get into the same boondoggle wording that I seem to be now. We're in this boondoggle where there's always a debate. Was that a medical decision? Was is a coverage decision? Are the medical groups responsible? Does the medical group appoint the guy that make decisions here, and so forth?

MR. ZATKIN: If I may. I think what you're focusing -- you're raising the question of what regulation needs in the context because what I think you're getting at is the specific issue of, for example, whether a medical director of a health plan is practicing medicine and making medical determinations.

DR. ALPERT: Some medical directors may have a license and some may not. Sure, if a medical director of a health plan doesn't have a license to practice and -- because if he has a license, he's already --

MR. ZATKIN: I understand. Because the delivery systems, I think, are being regulated as I described them, but if you meant by "regulation" that issue or another kind of regulation, then maybe there is a question.

MS. SINGH: Dr. Spurlock and then Dr. Gilbert.

MS. DECKER: First time check. It's an

hour and a half.

DR. ENTHOVEN: Okay. I just would like to have Spurlock, Gilbert, and then I'd like to ask Mary Griffin, who represents the American Medical Group Association, just to comment and then I'll take a straw vote on whether to delete this paragraph.

All right. Spurlock?

DR. SPURLOCK: Yeah. I just wanted to make one point about creating an organization, and I think we have to be careful about creating things that are going to be effective early on so that we don't have problems, and if we have no focus on what we're doing, I think we're going to have a problem with that. And I think what we're talking about -- I think that axing the whole line makes more sense to me -- that we have to be very precise about regulatory functions, that what needs to be regulated is something this group has been to be very specific. I think we just have to keep that level of precision about the specific area of regulation and function that we're talking about.

DR. ENTHOVEN: Okay. Brad Gilbert?

DR. GILBERT: It's true that DOC, when it comes through to do an audit will to go some medical group on some sample basis; so you're not seeing all medical groups.

The question to me is: We certify the credentialing of a medical group; plan B certifies the credentialing of a medical group; quality, quality

quality, quality; so the medical group ends getting certified or examined. They hate us because they say you're the fifth health plan that has come in in the past month; so is there a way to think about this entity streamlining manner so that if we accept that some processes used to say that this medical group is of quality and quality credentialing, we don't have to redo it?

MR. ZATKIN: I think that's addressed in the paper.

DR. GILBERT: If the issue is that they're not necessarily licensed, no. But if the issue is that not enough medical groups are being reviewed, that's a separate question.

DR. ENTHOVEN: I'd like Mary Griffin, who speaks for those medical groups, to comment briefly on this, if you would, please.

MS. GRIFFIN: Thank you. I'm just going to speak to paragraph B since that's what you're talking about. For those of you who don't think medical groups are regulated, Brad made some comment there, I will tell you they're regulated by everybody that could possibly be regulating them. I like the streamlining process, but I have to tell you the Medical Board already has the authority to regulate individual physicians; so you're first line there is talking about all entities that practice medicine should be regulated. They are, by the Medical Board of California.

I would also say, then, that for those of us who are in group practices, and I represent those physicians in IPA's and group practices, we are being regulated up one side and down the other. That is, everybody can come in, not just the health plans, but we also have folks that come in from NCQA to look at what we're doing in relative to --

MR. ROMERO: Mary, just to clarify that. None of the examples you've given so far are governal. They're all private. I mean you're calling that a regulation, and I can understand from your perspective why you would, but is there any state regulation of the groups?

MS. GRIFFIN: Yes. If in fact we do outpatient surgery, which many of the medical groups do. We have to be licensed to do that and then we are regulated by those that are -- that the government says be regulated, go look at what they're doing periodically; so our outpatient surgery centers would also be regulated.

DR. ENTHOVEN: Your diagnostic radiology?

MS. GRIFFIN: Everything.

DR. ENTHOVEN: Your laboratory?

MS. GRIFFIN: By various entities within that role, and so they should to some extent. What is concerning me here is that it looks like you're setting up to do more regulation, and I would ask you to consider that --maybe it's overregulating -- and to

consider whether or not that's really appropriate.

MR. ENTHOVEN: Okay. Thank you.

MS. BOWNE: So are you for keeping it or deleting it?

MS. GRIFFIN: I would delete that. I don't think that B does anything to help us here.

DR. GILBERT: Why wouldn't it, if you had a central entity, who for example certified your credentialing process and groups, then I don't have to do it, Ron doesn't have to do it?

MS. GRIFFIN: We are in the process of working on some of that and also 4, 5, all of that, we would support.

DR. ENTHOVEN: Thank you. Now, I'd like to have a straw vote on the question should we strike paragraph B. Would all in favor of striking paragraph B --

MR. KERR: I was going to suggest a compromise.

MR. WILLIAMS: I thought we were taking a vote.

DR. ENTHOVEN: Let's take a vote. So all in favor of striking paragraph B, please raise your right hand.

6.

MR. KERR: It would seem to me the industry sees a need for streamlining. It's not clear what's in the public benefit at this point and I hate to

recommend studies, but it seems that maybe this new organization, OSHO, or whatever it's called, should study the issue of what's the best to the public benefit to regulate and work with consumer groups, purchasers, and medical groups to look and evaluate the issue. I kind of hate to see it disappear because there seems to be some advantages from everybody's point of view. It seems to be premature to make a decision right here, but it certainly wouldn't hurt the new department to took a look and work with the state holders to try and resolve the issue.

DR. ENTHOVEN: Do you have some words, Clark?

MR. KERR: Some words, but Sara can always make them sound good.

MS. O'SULLIVAN: Can I offer a friendly amendment to that?

MR. KERR: Sure.

MS. O'SULLIVAN: That we not leave that in, "when OSHO gets created, it will look at this." OSHO might not get created or it might be a long time, so the legislature should look at this question.

MR. KARPF: If there isn't a latitude for consolidating it at the front end, once it's established there will be silos built around this institution and other institutions keeping it from coming together; so it's important to give us the latitude that it will need down the road to be able to consolidate.

DR. ENTHOVEN: Sara, did you capture the wisdom of Clark Kerr?

MS. SINGER: I think I did. Did you suggest a time frame or anything like that?

MR. KERR: I'd say the next year, by January 5th, 1999.

DR. ENTHOVEN: Within a year. So what are you saying? Within a year this may not be enacted?

MR. KERR: Right.

DR. ENTHOVEN: You were delegated by Clark to put his statement in.

MS. SINGER: I was just working on something that says "the legislature and governor within the" -- I presumed "governor, within a year should conduct a study to examine the merits of directly regulating any" -- we could either say "medical groups" or we could say "any entity practicing medicine that is not currently being regulated."

MR. KERR: For the benefit of the public.

DR. ENTHOVEN: Is that safe, Clark.

MR. KERR: Yes.

DR. ENTHOVEN: All in favor of substituting Clark's words, please raise your right hand.

Okay. Majority.

DR. ALPERT: Could I offer a friendly amendment to that?

MS. O'SULLIVAN: It already passed.

MR. LEE: This is not a real vote.

DR. ALPERT: This is coming back. To Clark, do you want to include the language "to the extent they can be shown to practice medicine" because that's what the debate has been?

MR. KERR: "To the extent they can be shown to practice medicine?"

DR. ALPERT: Well, the way it's written now, they can do out and do research on anybody they want and in defense of organizations that aren't just making coverage decisions and so forth and so on or ones that are directly regulated, they don't need to be -- if they are going to be provided by providing more data and so forth and so on.

It's just to the extent that they can be shown to actually practice medicine. In other words, is there really a hole here where somebody is making decisions and the decisions are impacting medical care directly to people that are prevented from having surgery and what have you?

DR. ENTHOVEN: Is that friendly, Clark?

MR. KERR: I think it is. It sounds like what you would hope medical groups are doing.

DR. ENTHOVEN: Yes.

DR. KARPF: I think he's a raising coverage question.

MS. SEVERONI: We didn't change the first 3 lines, did we?

MR. WILLIAMS: I want don't them to have coverage for electives, plastic surgery, if they want to do cosmetic surgery. They don't have coverage for that. They may choose to have it. They may choose to pay for it. That's just fine. I think when we cross the line from clinical decisions to coverage decisions, we're entering a different --

DR. ALPERT: I'm arguing -- I'm saying exactly what you are. I'm trying to prevent the same thing you're trying to prevent.

MR. WILLIAMS: I didn't draw that conclusion, maybe the others did.

DR. ALPERT: Well, maybe the language could be clear. That's my decision.

DR. ENTHOVEN: Sara, would you read us the friendly amendment?

MS. SINGER: "The legislature and the governor within a year should conduct a study to examine the merits of direct regulation of any entity to the extent it can be shown to be practicing medicine but not being regulated for the benefit of the public."

DR. ENTHOVEN: In favor of that amendment, of that subsequent friendly amendment?

MR. PEREZ: The reality is that what Ron and what Bud are talking about are the same thing. The language -- no. The sense of what you're trying to convey are the same thing. The language does not offer enough comfort that it really contains what it is that

you're concerned about and instead of haggling over the wording now, why don't we just agree that that's what we want to protect from and then we'll vote on it when it comes back to a straw vote?

DR. ENTHOVEN: All right. Now, Ron, Sara will consult with Ron and Bud and negotiate a language. Now, 1-C, please read 1-C. Just everyone read it.

Marjorie?

MS. BERTE: Actually my comment, I think, is sort of on the question of timing. My agency had been through a number of consolidations and efforts to restructure or reestablish a broken program. When you put any agency, and in particular the government, in a transition, it's a minimum 18 months' process just because of the structure of government, the approval process, the inertia, the retraining of staff, all the stuff that has to go on. If you make too many changes at once, you really can kill an organization. We had that in my agency. You get to the point where the staff is saying, "Please, no more changes for at least a year so we can maybe figure out what it is our job is now."

So on a practical level, too much at once it's dangerous. I think it needs to actually be acknowledged that it needs to be incremental, that you get some stabilization of process each time you go through a transition.

Mergers rarely generate a lot of savings unless you can identify in advance that function and

workload that's duplicated that will be eliminated and safe; so I think those kinds of things need to be part of that kind of a plan. The other thing I think in terms of stream --

DR. ENTHOVEN: What wording would you go with here?

MS. SINGER: "Any proposed consolidation should take the impact on or should take stabilization into consideration," something like that.

MS. BERTE: The other thing I think in looking at the multi-jurisdictional, and we just don't have subs spreads out amongst different departments, but they're in different agencies as we've all heard, is that some of the effort to streamline and coordinate really need to come from technological improvement.

For example, we have a board that licenses nursing home administrators. Now, why we do that at DCA, when it's an organization that licenses the nursing homes, is just dumb. I mean we've even scratched our heads trying to find out if there was a federal funding stream requiring it to be independent. We don't do anything in the medical organization unless we get some signal from DHS that they've a problem with a nursing home or a hospital.

I mean supposing the Medical Board is investigating a doctor or several of them and they all happen to be at the same facility, I don't know that on any uniform basis there's communication to the regulator

of the hospital or the plan that that's going on, and I don't know that we're anywhere near as effective as we could be. It's really a communication problem more than anything else.

We're looking at -- and a really good example, and I'm just discovering it, as we start to look at regulating all of the vocational and trade schools, many of the students that come out of those schools then sit for the exams of your various licensing boards. Well, there's never been any coordination there before. The licensing board can tell us by the candidates in which schools they attended, which schools are delivering a terrible quality educational product, basically ripping off the students who then don't pass the exam when we start to make a connection between what the licensure board knows about the schools and their candidates and our regulation of the trade schools.

Without saving any money in our new program we're going to be a hell of a lot more effective in making sure the students don't get ripped off for paying for education products that isn't preparing them for the job or profession that they want to go into.

We're talking about health and measure of educational quality. We're going to back into it by look at how successful the students are that are coming out of these programs. The same thing is going on all over the place in health care regulation where there isn't that kind of coordination, particularly on the

enforcement side where you've got a problem -- a physician is rarely out there practicing all by himself. There are nurses, there are hospital staff, there are all of those folks involved, and you don't have that level of communication-coordination. A lot of which can probably be facilitated electronically, and we're just not there technologically yet.

MR. ROMERO: Mr. Chairman, I've extracted some knowledge listening to Marjorie which may seem to capture the essence of your concerns. This, in essence, would be a new 1-D. "Any residual regulation" -- "regulatory authority left outside of OSHO should be directed to develop electronic information systems to share information that support enforcement." Now, we can be more specific about the time line or the details, but that was my intent to translate the concern you had.

MS. BERTE: Well, technology is just one our most glaring deficiencies, and merging different departments together in a brand new health agency is going to take five to ten years to do and we're going to be very focused on the changes and the transitions and less on technology.

MR. ROMERO: I see. All right.

MS. DECKER: Timekeeping. It's one hour and 48 minutes.

DR. ENTHOVEN: Ms. Bowne?

MS. BOWNE: Well, I think that Ron Williams and I both spoke to this issue before, and it's

not as though we're trying to say, you know, "Don't regulate us." What we're trying to say is that you need to think pretty long and hard about the unintended consequences before you put your indemnities and your PPO's in the same regulatory structure. There are very different laws. I think that unbeknownst you may be giving up a lot of consumer rights where under the Department of Insurance and the insurance law, consumers -- there are rules as far as when you notify, how much you pay, what do you do if you don't pay because you're basically looking at the paying claims after the care has been given. That's what the regulation is all about, the whole solvency issues.

I just think that there's a lot going on here. We're not saying, "Don't regulate. Don't coordinate," but we're saying before you slap this all together, there's a lot of work and examination that needs to be done, and I think that the unintended consequences will be to give the consumers not only less choice of product but less alternatives in their dispute resolution where now they can go directly to the Department of Insurance without even having to go through a grievance whereas under the other system you have to go through that.

DR. ENTHOVEN: Rebecca, that's what you're saying is part of the reasons for trying to push this downstream, which Ron was finding comfort in.

MR. BOWNE: I mean clearly they're related

and where they are related, they need to be coordinated and have similar kinds of systems, but they are very distinct differences

MR. ROMERO: Well, the language proposes that the decision take place within two years.

MS. BOWNE: Let's put it this way: I think you're going to have enough trouble getting this set up and getting it going, and I think that's extremely ambitious.

MS. SINGER: How about if we say where we've addressed Marjorie's suggestion as part of the examination to look at the stability, we can also look at the potential for benefit of consolidation?

MS. BOWNE: Fine.

MS. O'SULLIVAN: On that, I would like to discuss that a lit bit because I think we're assuming "benefit." I think the Task Force in recommending this consolidation is assuming benefit consolidation. We're not saying, "Legislature, we need you to decide if this would be a benefit." I think we're saying we think it's a benefit; so I think that's a big deal to put that in there.

MS. BOWNE: I think what I'm suggesting is to evaluate both the benefit and the detriment and then make the best decision.

MS. O'SULLIVAN: I guess I would say that that's what we're in the process of doing here.

MS. BOWNE: Without knowledge.

DR. ENTHOVEN: Lee?

MR. LEE: Two comments. First, I think that that additional language is fine in terms of adding it on the tail end, and it is saying with two years to consider it, not did do it in two years.

The other thing though -- I thought the DU language was about integrating both electronically and with other agencies is still -- something like that is important language in here because one of the concerns that I still have is that even with this new office, there still is an incredible need for coordination between existing agencies. I think the Task Force should knowledge that and acknowledge that there's an obligation on this office to work with OFSTED, which is now not part of it, to work with DHS.

In particular one of the things that does come up in dispute resolution is that consumers don't know any of these departments. They don't know DOI and DOC and we're recommending there be a 1-800 number that is for everyone. There are needs for integration/coordination regardless. I think that we need to acknowledge that. This streamlining doesn't do it in terms of the consumer interest into the system. That's another recommendation.

I'd also like to observe that we need to decide timing-wise how we're going to go through the rest because I'm getting nervous about our next afternoon and Tuesday.

DR. ENTHOVEN: Well, can we just --

MR. SHAPIRO: Can we just back up on point? If you look at your paper on page 15, No. 6, you can take ex officio, non-voting members, like the insurance commissioner and the Department of Health, and put them on that board, non-voting, while you're studying whether you need to move DOI functions in there. There's a model on 6 -- page 15, No. 6, where you have ex officio, non-voting department heads who contribute to deliberation which achieve part of your goal of this level playing field by simply having agency heads come together. I propose that as a supplement to the board option. I'm saying you do a board, then you have ex officio non-voting members, the insurance commissioner, the Department of Health, and then --

DR. ENTHOVEN: Or at least just some kind of health coordinating counsel, like the National Security Counsel Board? Where these people all came together. Quit laughing.

MR. SHAPIRO: Right.

MR. HARTSHORN: HCFA has already received about 12,000 inquiries or requests for, you know, applications for the PSO, whatever you call it, PSN. 400 of them were from California. I have one more question. We have to make sure that that's someplace in here. These would be provider sponsored networks contracting directly, and I don't see that. I don't know if it should be added in this one or --

DR. ENTHOVEN: These are going to be at risk?

MR. RODGERS: Yes.

MR. HARTSHORN: They could opt to be a PPO, I guess.

MR. ZATKIN: Terry, I think that the federal law says that they have to go through state licensure.

MR. HARTSHORN: They do? Where are they going to fit?

MR. ZATKIN: DOC.

MR. LEE: OSHO.

MR. ZATKIN: They are of a type that would normally come within DOC and then if they --

MR. HARTSHORN: My question is: Shouldn't we say that? Well, someone may argue they should go over to another agency.

MR. ZATKIN: Alain, just one comment because I think I'm going to vote against C, and the reason I am is I think the premise, this so-called level table premise, doesn't really hold unless we're going to say, and it has nothing to do with the entity, it has to do with the standards. Indemnity insurers don't have basic -- they have very different basic benefit requirements. They offer much broader products. Essentially the focus is financial because they don't have networks or they have very limited networks. The Knox-Keene plans are really delivery systems; so the

focus is very different and we can put them all together. It isn't going to matter functionally because they're offering very different products.

DR. ENTHOVEN: Let's take a straw vote on that one, then. We're going to strike C and then I'll bring some of this other language back in as a substitute.

DR. ENTHOVEN: All in favor of C about as it stands?

MR. LEE: With the additions that we've given to Sara earlier.

DR. ENTHOVEN: Right.

MS. FARBER: What am I voting on again?

DR. ENTHOVEN: C as it stands. This is in guidance to Sara in rewriting the papers.

The majority is 4 in keeping C.

Now, there were suggestion for language that says there's a great need for integration and coordination among departments, and Michael suggested bringing in the idea an inter-departmental advisory counsel.

MR. SHAPIRO: No. I said ex officio board. We ought to wait for that option.

MS. SINGER: The coordination idea might fit nicely under No. 7.

MR. WILLIAMS: I have one clarifying question, if I may. There's been some discussion that the -- through the stock loss arrangements that many of

the self-insured companies have, that the Department of Insurance or the Department of Corporations could end up with jurisdiction over self-insured plans. I don't know. There's been some litigation. I don't know where that stands and I just want to raise that and ask people to be fully informed of the implications of their decision.

MS. DECKER: It's the reason we didn't take out that kind of insurance. We didn't want to be subject to DOI.

DR. ENTHOVEN: I want to move on now to page 4, No. 2, Appropriate Leadership, A. Without objection I think we're going to assume that's a non-controversial point. The controversy will come in 2-B.

HON. GALLEGOS: There has been a request, I don't know if it's come to you or your staff, from a member of the public to make a few comments on this issue. It was from Scott Syphax from California Medical Association, and he wanted to commented on this issue when we brought it up, if it's possible? I know we've done that on some of the other issues.

DR. ENTHOVEN: On No. 2?

HON. GALLEGOS: Yes.

DR. ENTHOVEN: Okay. Is that person here?

MS. SINGER: He's only indicated interest to discuss the paper. I didn't have any particular recommendations that he wanted to discuss.

DR. ENTHOVEN: Are you just going to make a remark about 2?

MS. SINGER: 2-B or in general?

MR. SYPHAX: Just that one.

MR. ENTHOVEN: Tell us your name, please.

MR. SYPHAX: Mr. Chairman, members, my name Scott Syphax and I represent the California Medical Association. Thank you for allowing me the opportunity to make a comment at this point in the presentation, and I'll try to be as brief as my predecessors up here.

The CMA has taken the position that the most effective structure for whatever entity it is that this body deems is going to regular managed care would in fact be a board-executive officer model. And the reason for that is because our current regulatory system, which is a governor's appointee that reports through a number of secretaries, assistant secretaries, deputy secretaries, assistant secretaries, assisted on the side by an advisory counsel, is basically -- what it is that we see is a variation of what's being proposed for this new office of health care oversight.

We believe that this model has proven itself ineffective. I'm not going to recover the points that have already been abely addressed, but in saying that within the last gubernatorial administration, there has been a succession of commissioners and corporations and every time that there's a change in leadership, what happens is that the agency lurches from policy

initiative to policy initiative. Each commissioner comes in with a different set of standards and a different sort of take on what it is their job is. And what happens is there is no predictability of consistency in terms of their approach to regulating Knox-Keene plans.

Secondly, the problem with the current model and also the proposed model that we see is that there are no regularly scheduled intervals for the public to come in contact with executive management. One of the things that a board-executive officer model gives you is it gives the public an opportunity to come in on a regular basis and provide leadership, both the day-to-day manager and also the policy leadership, meaning that board of commission, with raw and filtered data on what's happening now in the marketplace, not just from the people who provide the service, but the people who the service is provided to, and it's that sort of fundamental grass roots sort of nexus that takes place that we think is key in order to try to address a system which is involving to beneath our feet as we speak.

Right now we're trying to get a snapshot in terms of -- all of you are grappling with this issue and very ably so, but your grappling with this issue primarily to find what is it you're trying to regulate and how do we get our arms around it?

The problem is that by the time you come

to a conclusion, the word has changed and the world is going to continually change and so you have to have that ongoing dialogue taking place, what it is this model allows. What it allows, in brief, consistency in leadership, direct tie between management and day-to-day oversight for policy, and finally that it allows public input to sunshine in on the process.

DR. ENTHOVEN: Thank you. We will now consider taking --

MS. DECKER: Time check. Two hours plus.

DR. ENTHOVEN: All right. We are now going to have a straw vote on essentially two models before us.

MS. BOWNE: Alain, we haven't had any real discussion on this --

DR. ENTHOVEN: We've had a lot of discussion against boards versus single head.

MS. SINGER: Members, if I could just pose a question to you. Right now there are a total of eight recommendations and several of them have sub-recommendations. It is now 2:00 o'clock and it's just a matter of whether or not you want to discuss each recommendation or just take a straw poll on the concept of each recommendation. Otherwise, I mean we have numerous papers that we need to get through today.

MR. SCHLAEGEL: Mr. Chairman, earlier I did come out in favor of the one man being in charge of the agency and before the lunch hour under the excellent

tutelage of Michael Shapiro, I now see the wisdom of the board.

DR. ENTHOVEN: All right. We're going to have a straw poll now.

MS. O'SULLIVAN: I want to propose that we keep both concepts on the table between -- this is new, this commission idea, and I think there's a lot of merit to it and it's the first time we looked at it. I think we ought to keep both of them on the table until --

MR. LEE: What's the one? You can bring it up again in December.

MS. SINGER: It's just a guideline.

DR. ENTHOVEN: To how we write the paper. So what we want to consider is "a single-appointed head with advisory board versus an appointed board with an executive officer." I think those are the two.

So all in favor of "a single-appointed head with an advisory board," please raise your right hand.

9.

How many in favor of "appointed board with executive officer"?

13 -- 14.

Well, we'll write it then as "an appointed board with executive officer." Next, item 3, streamlining regulation of medical groups. We can do a little wordsmithing to say, "The governor and legislature should give OSHO the authority and

responsibility to facilitate the existing oversight of medical groups, IPS's, and other entities that enter into risk contracts with Knox-Keene plans, including solvency and quality audits, the credentialing process, monitoring provider compensation arrangements at their disclosure, dispute resolution processes, and other areas, if necessary.

This oversight" -- there's a little change -- "should, to the extent possible, be exercised in a way that it would reduce the cost for providers and health plans. "

I'm just proposing just a slight -- very slight change here. The intent is to streamline and reduce the costs, especially the cost burden on health plans and providers, not just that it could be done, it should be done. Your job, OSHO, is to do it that way. We're trying to bring the cost down so that we can improve the administrative process. So it's a concept.

All in favor of the consent, please raise your right hand.

It's a majority.

Next, we will move on to 4.

DR. SPURLOCK: I had an issue to discuss.

MS. BOWNE: We're not discussing, we're just voting.

MS. SINGER: If you have comments, send them to staff.

DR. ENTHOVEN: Please read No. 4. I'm not

going to read it out loud. There are no suggestion changes here, but it emphasizes "in conjunction with other public and private bodies," which is a change in the way they've been acting.

DR. NORTHWAY: On what you said about 3, can 4 be consolidated with 3?

DR. ENTHOVEN: That's kind of an editorial thing. We'll welcome your suggestion on Monday morning in my fax. But are these the right principles? Let's not wordsmith it, but is the concept -- I think this is not controversial.

All in favor?

All right. Now, we come to No. 5, Streamline Solvency Audits, and here the idea is the regulatory agency would by RFP process identify accounting firms who are qualified and work out standards of solvency for different types and conditions of risk-bearing entity, and then these firms would be certified as qualified to do the audit. Then the medical group could call on the qualified firm of its choice to do an audit and produce a certificate of solvency, which would then go to the health plans and to the regulatory authority and anybody else who wants it. So this would get this bit of oversight done without causing the health plans to have to review the solvency and it would be a once-and-for-all process.

Now, there could be an objection by Terry or Ron or somebody and say, "Look, if one of these

providers groups goes belly up, we're going to still be responsible for the -- so you may be a paying a price for this; so this is seen as a significant effort to reduce costs all around.

Any discussion?

MS. DECKER: Go for it. Done.

MR. HARTSHORN: We need solvency audits, but we need it to streamlined.

DR. ENTHOVEN: Okay. All in favor? Great. Now we're really rolling here.

Now, "Streamline Quality Audits." I mean I think it's almost embarrassing that this hasn't happened a lot sooner and PBGH has even shown the way in CCHRI. So same story on quality audits?

Okay. 7? Again, this sounds like they're not doing it. There's a lot of --

Les, do you want to just comment on that?

MR. SCHLAEGEL: I just want to vote for it.

DR. ENTHOVEN: Okay. All in favor, the concept of 7?

MS. BOWNE: Well, one could have the idea, here on the last line that they differ greatly. On the last line, I'm not sure if it's saying -- in other words, like Department of Insurance would regulate us where we differ from Knox-Keene? Is that what it's saying?

DR. ENTHOVEN: Yes. But we're not trying

to change the jurisdictional -- do you want me clarify "no change in jurisdiction"? Okay. So we had a vote on that, 7?

MS. SINGER: Yes.

DR. ENTHOVEN: All right. 8, "meet the challenges presented by accelerated industry change," the concept? 8-A, the concept.

This is a direction to provide a regulatory process where decisions get moved out and documented and rules do so that plans, what they get, doesn't depend on which person they happen to get so that they can be guided by cumulative published regulations and cumulated data decisions.

Terry, did you want to comment on that?

MR. SHAPIRO: Are we reading paragraph by paragraph on this one?

DR. ENTHOVEN: Yes. Okay. Concept, all in favor?

DR. ENTHOVEN: Okay. 8-A?

Okay.

8-B? This all speaks to deficiency.

MS. BERTE: I just have a question of tone. To sounds like counsel bashing to me. I think there's way of saying this without suggesting criticism to counsel.

DR. ENTHOVEN: We certainly don't want to bash the counsel. This was in 8-B?

MS. BERTE: I was concerned about D-7,

where it says, "You assign counsel unless and until concerns over counsel's objectivity arises." I'm not sure you need to say something like that.

DR. ENTHOVEN: Well, then that's the argument we got. Oh, but after a while, they'll be in the pocket.

MS. BERTE: All I'm saying is I'm not sure you need to put it in that tone.

DR. ENTHOVEN: But that was argument for not consistently assigning counsel.

MS. DECKER: Can we just say "consistently assigning staff" or "take steps to insure continuity of review messages" or something without meaning a specific role?

MR. LEE: The point is that we want both continuity and objectivity both, and that's the goal without saying there's that there's concerns or not.

DR. ENTHOVEN: We will rewrite it to say -- what we want here is "continuity and objectivity." That's the concept.

8-B, all in favor?

MS. SEVERONI: I just want to come back to something Tony raised about improving technology, and I'm just wondering here in this whole section of No. 8 if we want to build in any kind of --

DR. ENTHOVEN: Yeah. Very good idea.

MR. RODGERS: I have a question. To do this, you have to create a different type of entity than

just another department of the state because if you load on all the state requirements these, in essence, will create the same thing you've done all along in terms of hiring freezes. Even when they have the money, they still get frozen because there is always somebody else who is over spending.

If you create an authority that is a public entity, publicly accountable, but does not have to follow the same rules as the state as protected from that, and that's controversial, I realize, is the only way that this organization can efficiently operate because the only way that the government or legislature can effect this is don't give them budget or control the budget by freezing or by not allowing them to procure or interfering in the procurement process, and that's why you need to think about what it will take to really to do this.

MR. ROMERO: If I can just respond to that specifically. Tony, I spent a lot of my last couple of years on this issue, not streamlining government and making more efficient and competitive so I burn with your concern. But I'm concerned about setting up this quasi-public organization, which is the way I interpreted your suggestion because the thing over which we want to have regulatory authority is just really important, and I'm concerned about legally and possibly even constitutionally about delegating that much authority, going non-governmental organization. I

completely appreciate the spirit of what you're saying, but I don't know if that's the right way to say it.

MR. RODGERS: Here's an option. You have the entity's governance as accountable back to the public, et cetera, but the staff itself in the general processes can be separated in a way under an authority organization. There is a way to do it. We did it actually with the local initiative, but I'm only saying that if you don't make a statement like that and they just put in another department, it will have all the same --

MR. ROMERO: I agree with that completely.

DR. ENTHOVEN: Tony, could can you write us a page or two memo and we'll fax it out to everybody and take a side-by-side look at it. I'd be very interested, and I think of CalPERS, that they've got a certain amount of autonomy, which really is a blessing.

So 8-C, "Legislation, allow health care service plans to consolidate minor amendments that occur during the year in one annual filing."

MR. SHAPIRO: Just one comment. This actually may be controversial. I support it but with one caveat. One person's minor amendment is another person's material modification, and one thing you might want to think about, and I talked about this, is maybe have the department simply certify that it is minor and to go into the annual filing as opposed to having arguments at the end, not approve it or review it.

Maybe "certification" is not the right word, but if you're going to tell them that they can no longer preapprove these, then you let the industry decide how to characterize it.

We've had conflicts on that before. It's a good streamlining effort, but you need some reference to a safeguard in there, I don't know what that is, to insure that you avoid later conflicts that you shouldn't have folded that in with material modification.

DR. ENTHOVEN: Could we call upon DOC, develop regulations to define that?

MR. SHAPIRO: That's fine, as long as there's some caveat in there in some language.

DR. ENTHOVEN: So 8-C, the consent is OSHO, and this will include regulations to define that so that we -- okay. All in favor?

Thank you.

9? "Independent organizations to evaluate the use" -- excuse me. 8-D. "Evaluate the use of the recent DOC budget augmentation to determine its impact on responsiveness and to assess the need for additional or reallocated funds given to proposed tests for streamlining."

What happened last time was a great big pressure thing, including holding up Keith's -- he had an independent --

MR. SHAPIRO: His confirmation. My only comment, I'm going to object to this. This has been

done. If the California state auditor was directed by a joint legislative thing to report in 1999 on how the funds were spent, whether they were efficient spending, and might want to suggest other issues they should look at as opposed to have a new entity to it, over and above that.

That was an issue that was debated because they wanted to make sure the funds were spent. If there's going to be independent state auditor report on this, I'm not sure if it's any different than this. I just add that information.

MS. O'SULLIVAN: So we can just take out "independent organization" -- "higher independent organizations and should evaluate"?

DR. ENTHOVEN: I would regard that as a friendly amendment.

MS. DECKER: Say that again, please.

DR. ENTHOVEN: Maryann would just take out "higher independent organizations and should evaluate the use of the recent" -- we want to get some advisability on this, some analysis of how much you need. I'm hoping with the streamlining things that that may reduce the number of people in some parts of it.

Okay. In concept, all in favor of A-D as amended by Maryann?

Okay. Good. Thank you.

Last one. This is Material Modifications Default Approval. What happens now, as I understand, is

it's no criticism of the excellent people in DOC but because of the shortage of budget and all these other things, that proposals come in and they sit there and then they don't get approved in the 60 days like they should be and then they get extended -- I forget the methodology you guys use, but you have a technique for doing that -- and it's to say at least at the end of 60 days if it hasn't been disapproved, then the health plan can go ahead and not be subjected to retribution. The correction might come prospectively, but not to be punished for.

MS. O'SULLIVAN: I think if there's a problem with DOC moving too slowly, then maybe you want to put some language in here that the legislature should be monitoring that and taking action to make sure these things happen timely, but if we think that these modifications need to be approved by an agency, then I don't think we should say go ahead and do it if the agency has been too slow because it's processed.

DR. ENTHOVEN: Well, it is a problem of slowing down innovation. Comments on that?

MS. O'SULLIVAN: Then we should correct the problem, though, and not get rid of the regulation.

MR. RODGERS: I just want to point out that where there has been these requirements placed on an agency, what they will do is they will give you one comment, a general comment, say it's unacceptable, send it back to you, and start the clock again.

I know what you want to do. I think there needs to be some parameter placed on the improvement process because some material amounts are very complicated, and do require time. Others should be allowed to go through, but they back up their ques when you're sitting there, and I think there's got to be a better process, an agreement up front, on how long something is going to take and then that is what they have to complete it in.

In other words, they say this is a 90-day review or this a 120-day review and that's it so that the plan can then plan, instead of saying it's all 60 days. What they'll do is they'll send it right back to you and say, "Well, we find a typo in this."

DR. ENTHOVEN: So at that point the plan can go ahead, and DOC can still call it back.

MS. O'SULLIVAN: I think the process needs to be corrected.

MS. BOWNE: I think what Tony's is saying is that they look at it, they identify the time frame, and they act within the time frame.

MR. RODGERS: Right.

MS. O'SULLIVAN: And change the time plan if you need to change it. It doesn't help the plan if you sent them out and they don't do it, and say, "Oh, no. We don't need it." That doesn't help planning.

DR. ENTHOVEN: Tony, would you promise to -- is there general agreement on the concept?

MR. PEREZ: As modified.

DR. ENTHOVEN: Yes, as modified, yeah, Tony's concept. And you'll fax Monday morning, when I come into work, that will be some type of --

RODGERS: If I ever get home from this meeting, sure.

DR. ENTHOVEN: -- words to describe that because that makes a lot of sense. We just have to have some kind of commitment and finality, and so if you don't even like this idea, you could call it back without out punishment.

MS. O'SULLIVAN: That's what we're taking about.

MR. WILLIAMS: I think that the concept that you can file something and whatever the appropriate statutory time is for it to be reviewed, should be taken. If you don't hear at that point in time, then you ought to be able to go forward and operate your business. Now, if the department comes back and says, "We don't like that" or "change it," then the plan ought to obviously comply.

There's a second part of this which has to do with you make the changes and then there's a potential for exposure for some kind of disciplinary action because what you found, you belief to be accurate and you believe to be okay, later you discover it's not and you could be subject to disciplinary action. There really are two separate concepts in here.

DR. ENTHOVEN: Well, we don't even need to vote. Sara will work with Tony who will talk with Ron and we'll try to -- Okay. Now, we're going to have a five-minute break.

(Brief recess.)

DR. ENTHOVEN: I'm able to report on reliable authority that the Cal Bears are ahead of Stanford in lost turnovers.

Now, we're going to spend exactly one and a half hours on -- from now until 4:15 we're going to discuss new quality information. I guaranteed Maryann at 4:15 I'm going to pound the gavel, and then we will take up vulnerable populations because she's done work on that. That will leave us with a reasonable but heavy schedule for Tuesday.

Clark?

MR. KERR: Thank you very much. This is the new quality information paper and Rodney and I are going to sort of run you through this very quickly. I think the only reason we were allowed is because Cal is ahead in lost turnovers and behind in the game.

Everybody it's 5-D, is where the paper is. We will go through this. We want to preface it by saying that, of course, we hope that you will note that Rodney and I are totally behind this. It is bipartisan obviously since we represent different groups here. It is also that one of the members is a physician and a member of a health plan and another one is a consumer

with some employer background; so I guess it's okay; right?

We wanted to point out that really the objectives of what we are attempting to get to are really sort of fourfold. The information is basically to try and help consumers make better choices between health plans, providers, and options for different treatments. It is also to help providers improve quality of care by advancing evidence-based medicine to find out what works, under what circumstances, and with whom. It is to help the public and private purchasers better determine value when they make their purchaser decisions, and finally it is to help the policymakers better safeguard the public's health.

We have a number of suggestions, modifications, and clarifications. Many of them came from your ideas, which we thought were very good. We did not redraft the paper out of respect for your time, but I'd like to run through several different concepts right off the bat here.

First of all, we clearly recognize and the adjusted paper will show that this that there's a clear cost to collecting data, and we recognize this and we are suggesting that data should only be collected if it does one of two things: Either it helps providers improve the quality of care and/or it helps consumers and purchasers choose quality health care and providers for appropriate treatment options; so those need deserve

a criteria.

We also acknowledge right off the bat some things people have said that we're not ready to collect all of the information we're proposing yet. There's obviously is a certain amount of way that outcomes have to develop before we're able to do some of the things we're proposing, and we also recognize that the detail that we're proposing here in terms of the various levels and what we're asking for may require electronic medical records to be able to make it feasible to evaluate performance at these levels.

DR. ENTHOVEN: Clark, could we clarify something on terminology as between, like "encounter data," which can be merged with lab data, pharmacy data, and electronically packaged up versus when you use the term "medical record," in many minds that evokes the Holy Grail that nobody's gotten to yet of the complete records of Starevol or Treavol (phonetic) -- would you accept the friendly amendment of -- we're talking about encountered data or do you mean more than what I just described?

MR. KERR: We certainly, for the initial standparts, will get into this in more detail. We're talking on the same terms as the PBGH sponsor to help data summit, that that group was talking about. We certainly don't want to stop there, either does PBGH or any of the other members, in terms of really getting to the full medical record data but when we get to the,

Rodney is going to talk a bit about that. But there's no question the first part is what you've just talked about, Alain, so that's friendly terms of the first step.

DR. ENTHOVEN: Okay.

MR. KERR: We also have a principle that the state should not duplicate private sector efforts. There are many efforts going on. What we're suggesting is they complement each other, they work together, and in cases where something is not being done that should be done, something is not being done that we think should be done, is not being by the private sector, that's a place for the state.

Now, the state has a couple of options to move forward. It can either do its own work, such as OSHO has been doing in the past, or it can certainly contract out with either academic or research groups to do those types of things.

Finally, we wanted to point out that the first think on our list is the risk adjusted payment issue. We're dropping that from our paper since it's being discussed in other the paper and already approved.

The first area we would like to discuss is the one talked about, Alain, and I'd like to turn over Rodney on electronic medical records.

MR. ARMSTEAD: I agree with you. Just right up front, Alain, that the intent here as far as electronic medical records that what we need to talk

about and get our arms around most immediately is around the issues of encountered information or encountered data so it's really bringing all that element of encounter that is laboratory, radiology, pharmacy, and what have you, we're converging that to be able to package it in a way to be able to make some broad sale, large scale comparison relative to quality, evaluations, and looking at that from the aspects of quality and utilization. I think additionally in the context of important issues around confidentiality, you know, that those things will need to be obviously appropriately flushed out.

Then I think the next level, which is more than just that, is what is going on in the context of medical groups or specific medical groups? That may be something reasonable to look at as to that next level of electronic medical records of how things are going, for example, with the Pegasus types of work and what have you that's being done when it's owned by HBO; so being real brief, the intent is exactly as you stated it. That's what we mean, but I think that it would be prudent to move, you know, clearly technologically to the next level and certainly discussions would need to be around the area of how it's done, where it's modeled at, and where we would look at in studying those types of things with some medical groups and dollar contributions on how to basically look at that from a public sector perspective.

DR. ENTHOVEN: Great. Thank you. Let me introduce Carol Horhaus, MBA, who's part of my team and who's been working on this. Any discussion, comments on -- let's say, we just renumber 2 as now 1.

MR. KERR: I just want to make one more comment. We have specified some dates in there, trying to move this situation on. The 2002 to 2004 year transition phase with the 2002 being for the larger, say, medical groups and the large health plans, and 2004 for the smaller clinics, rural areas and so on. I did have a chance in this past week to talk to both Pat Powers from the Pacific Business Group on health and Peter Wald who heads up the data effort for PBGH, and they both said that they found that type of setting and date to be very helpful for the effort.

DR. ENTHOVEN: Okay. J.D.?

DR. NORTHWAY: I think it's fine. I think it should be recognized in here somewhere that this is a tremendously expensive venture and yet is still sort of in the alpha phase as I understand about actually making this a practical kind of thing. Everybody things it can be done and it probably can be done, but it's extremely expensive.

DR. ENTHOVEN: Well, may I just comment. I took a quick poll of a couple of health plan executives as to what is the state of play with you and your medical groups, and they said it kind of various all over the place. Some of their medical groups

regularly report good and encounter data, others report nothing, and others are kind of in between. Really there's a need for this for --

DR. NORTHWAY: I'm not talking about the encounter data. I think that's probably something that's not relatively easy. I'm talking about going through electronic medical records.

DR. ENTHOVEN: Okay. We tried to clarify that by saying, strike "electronic medical record," and say "encounter data plus lab, x-ray and pharmacy."

DR. NORTHWAY: Okay. I apologize.

MR. KERR: That's the first step. We don't want our idea to be lost there. There are so many many quality things that come into the importance of alerts to avoid some of adverse smoke reactions, the importance of props to be able to help with promotion and immunization reminders to physicians and nurses and so on, the mammographs, all those things, the decisions and support that can be built for all those systems of systems because it's difficult for health providers to be up to date on so many things once you've made a diagnosis, to think that it would be a mistake to stop just at that point, but that is the first step.

DR. NORTHWAY: I'm not arguing against that, Clark. I'm just saying that somewhere in here it ought to be noted.

DR. ENTHOVEN: J.D., as I'm sure you know, for quality monitoring to exist, there's just so much

you need to have encounter data for, like in so many cases, if this, then that.

DR. NORTHWAY: All I'm talking about is encounter data.

DR. ENTHOVEN: Like all this very costly auditing for aegis. If you have the encounter data, you can just tell the computer "Pick out my 55 year-old-woman and see whether they had a mammogram or whatever.

Okay. Decker?

MS. DECKER: I just want to mention that as a person that has to deal with employees and their families and the retirees that are frustrated by the health care delivery system, that having things like electronic records would really facilitate a lot of the decision making that goes on and that even though this may cost something in the mere time, I think it really is a long-term cost savings because it improves -- I can see a face over there that goes "No."

I just feel like, when I deal with the complaints I deal with, much of them could be at least reduced and/or minimized if this information was flowing in an appropriate manner. The biggest complaint that we have to deal with is the referral issue and the biggest reason referrals supposedly don't happen is because the information isn't at the right place for the next level of review. Although I recognize it could be costly near term, I think it's worth taking the step.

DR. ENTHOVEN: Thank you. Karpf?

MR. KARPF: I am very much a proponent of an electronic medical record and I'm very much a proponent of getting providers to define themselves quantitatively. The question is: What is the progression and what is reasonable to expect over a period of time, and who's going to foot the bill? In my organization we are moving towards an electronic medical record and we will invest immense numbers of dollars into that; yet I can't promise that we will get there in any reasonable period of time.

When we start looking at smaller providers or groups, I'm not sure who foots the expense for that; so I think if you set your goals so broad that they're not achievable or not deliverable, you will not even have the opportunity to achieve any goals that will be helpful and are deliverable at this period of time.

I think this state has had some experience with trying to present data on outcomes in more limited cases like myocardial infarctions, like bypass, and it's taken them a couple of years. I think Dr. Werdegar can speak to that issue to be able to get clean data. I know in Pennsylvania it took them several years to gear up to get data on cabbages and to get data on myocardial infarctions, and they imposed that information system.

I just would just hope that we could move this process along by developing some set of manageable goal at the beginning so that can, in fact, start

getting data and do in a way that all providers can participate in and then set longer term goals. If we just look at the longer term goals, we're not going to get anything in the short haul.

DR. ENTHOVEN: Right. But are you comfortable for the short haul with encountered data if I kick the 1500, patient-provider diagnosis procedure?

DR. KARPF: Yes. There is data that is available that all hospitals have to fill out that will give you some opportunity if you start their rising definitions and you ask everyone to report that data. When you say "encountered data," if you say that you want all providers to be able to give you pharmacy data, all lab data, and everything about immunizations, everything that has happened to the patient, there are very few providers who can do that today.

DR. ENTHOVEN: Just if you have in your computer "patient-provider diagnosis procedure," the extra 1500 form?

MR. KARPF: Yeah, you can give your ID and stuff like that. There are data elements that can be organized that will start giving you pieces of this information. Something that needs to be done is there needs to be some definitions defined also.

MR. KERR: Michael, one of the things we're proposing is this public-private Task Force to consumers, purchasers, and providers recommended strategy, and, of course, that strategy would be where

are the priorities and what's the time line in immunizations, cost issues and --

DR. ENTHOVEN: Sara or Carol, how does this relate to the data summit, or does Les know about that?

MS. HORHAUS: My understanding is that we were going to work with the summit on those particular issues. We were not going to recommend a new panel to do that precise task, that we would support the summit.

DR. ENTHOVEN: So we want to put in words here "this is in collaboration with PBGH and the data summit." Is that a meaningful word?

MS. HORHAUS: Right.

MR. KARPF: I'd like to also point out one other thing. It's not only an issue of technology. It happens to be an issue of language and definition, and as an example when we were providing data for HCFA, when we were applying for a center of excellence for cardiovascular disease and we had to start giving the data on cum morbidity and complications, it turns out that our physicians have been very interested in complications because they wanted to understand that, and so they were very liberal in their interpretation of that; so the drop of dramatically of three was considered a GI bleed, pull everybody out, who might have had a possibility.

They weren't very good on cum morbidities; so when we looked at the raw data, we looked we had very

healthy people who may be very sick at the end. We had to spend immense amounts of dollars to go back through that data and risk adjust it to demonstrate that, in fact, our patients were sicker than they looked at first blush when the complication rates weren't really out of portion.

There's a lot of work to be done not only in the technology but very substantial amounts of work that needs to be done in standardization of languages and in setting a criteria.

DR. ENTHOVEN: You're right.

Bruce?

DR. SPURLOCK: I just wanted to make a couple of comments about No. 2. I actually like the idea of a transition period, based on the size and research of the medical groups, health plans, clinics and hospitals. I will say that as a consequence of that, if you ever want to promote consolidation, this is exactly what would do it and if you ever wanted to push people towards Wall Street, this would absolutely, positively do it. So we're going to have very large systems, very large medical groups, except for in outlining areas because the reason is because of capital. There's no question that capital drives the information market right now, and that's what's going to happen over the next three or four years.

I would like to recommend in the language because I like the idea that we're going to collaborate

with the data summit and I should give a conflict of interest. I'm on the Steering Committee of the data summit; so I potentially win in this issue even though I don't necessarily agree with everything.

I would just say that we transition not only by the size of groups but also by the component of the electronic record that you're alluding to, Alain, so in other words, you wouldn't necessarily have to have everybody jump on with all three or four of those components. You can jump on with pieces at a time, but that there's a transition period that we would implement all of those things over a certain amount of time because I think it is pieces of the electronic record that we're talking about and when nirvana hits in 2025, we'll have the entire medical record, including Bois, Chappy, the whole bit that we think we won.

DR. ENTHOVEN: So that's all? Like pharmacy is in the computer now.

DR. SPURLOCK: It's just not stored standardly. It's stored differently in different pieces. That's the difficulty with pharmacy data.

DR. KARPF: And may not communicate with other areas that you're interested in; so you can't necessarily merge databases very easily in many facilities. And trying to do that, it becomes very, very expensive.

DR. ENTHOVEN: Les, did you --

MR. SCHLAEGEL: In the interest of time,

the previous two speakers took care of my issues.

DR. ENTHOVEN: So do we have agreement?

MR. WILLIAMS: There's one issue that I don't see addressed here in data, and I think it's a consumer issue that, I think, will be facing all of us shortly. I think, particularly, the managed care organizations need to be investing in being compliant with the year 2000 in terms of their systems and their infra-structure. If the estimation and dates don't seem to be a problem, wait until the 2000 if people aren't compliant with the ability to produce dates in the year 2,000.

MR. KARPF: I'm a bit disappointed. I thought Ron was going to fund the electronic medical record.

DR. ENTHOVEN: Okay. So that's item 1.

MS. HORHAUS: I'm just wondering, would it be helpful to suggest the following wording as far as coordinating with the summit on standardization of data we're talking about?

That "the Task Force recommends that the health plan regulatory authority be aware of, participate in, and actively help, where possible, ongoing private sector efforts such as those that have been initiated collectively by PBGH, 9PAC, AMGA, CMA, and CAHP to develope standardized eligibility enrollment and encounter data."

Does that hit on --

DR. ENTHOVEN: That's what they're doing.

DR. SPURLOCK: That's one of the pieces. There's 15 pieces in there and that's one of big ones.

MR. WILLIAMS: I think one of the things we need is maybe a broader archecticture that ends up where, I think, clark would like to go. And yet starts out with the basic things like eligibility, data, billing information, take eligibility to help fund employers, to health plans, pharmacy date, and encounter data and then moves up the spectrum. It think that's one of the things missing is that model.

MR. KARPF: Other states, Clark, have actually imposed information systems. Pennsylvania imposed the use of I think it's call Medi-qual for all hospitals, which ended up being relatively expensive but did get standardized data; so I think we've to be careful that if you want to do that, you should be very, very up front and do that.

MR. KERR: I think the basic philosophy behind the PBGH effort is to have an open architecture type of systems, that you're not wedded to a certain system. It only goes a certain way. I think it makes a whole lot of sense to me.

DR. ENTHOVEN: Yes. Helen?

DR. RODRIGUEZ-TRIAS: I just did a quick read of it, but maybe I missed it. I don't see "confidentiality" anywhere.

MR. KERR: No. That's what we want to

mention. We want to very much highlight that. This is all contingent on confidentiality and privacy for individual patient data. We do have it there.

DR. ENTHOVEN: We dealt with that a while ago.

MR. LEE: But it is here in No. 2, but it will be more emphasized.

MR. KERR: It will be emphasized, right.

DR. ENTHOVEN: So all in favor of 1, the top of page 2, formerly 2, now 1, as modified?

Is everybody together on that? Thank you very much.

Now we'll move to formerly 3, now 2, "Improve the flexibility of state health data programs to support new quality information issues at present and into the future."

MR. KERR: Basically the idea here is that the state is one of those that will play a role in being able to provide information and that the current system is very cumbersome and it's an attempt to really move from a statutory to a regulatory type of situation.

As you know right now, each data element, it's a really a required micro managing on the part of the legislature. Every data element, added or subtracted from the data system, has approved by each House and be signed by the governor. What we're proposing is that there be legislative oversight of the process. The legislature would set the broad policy,

but they wouldn't be forced to micro manage every single data element. We are the only state among the 50 states in the United States that requires this kind of process, putting the legislature under this situation.

What we're proposing instead that there be Blue Ribbon group made up of providers, consumers, and purchasers that would make the decisions on the individual data elements per se, not the broad polices, but individual data elements. They would base -- and we will add this into the text -- the would base their decisions based on an evaluation of cost of benefit on the information, recognizing there's a cost. They would be vigilant in attempting to eliminate any redundant or useful information that's in the data set, and they would also utilize sampling techniques, when possible, to minimize the cost of the collection. Those would be the three things we've mentioned.

DR. ENTHOVEN: Comments? Bruce?

DR. SPURLOCK. Bruce.

DR. ENTHOVEN: It's getting late. I'm getting a little blurry.

DR. SPURLOCK: I want to thank Clark for going a long way and meeting some of my concepts that I had in trying to restructure some of this. I should just give a little background about some of the history about why there's concern about statutory versus regulatory approach on the data elements, and from my own personal perspective, data is kind of like heroine.

You kind of get addicted to it and you like more and more of it. The fear and the concern -- many, many years ago, when the data elements were limited was that once you start and you develop this process where you can add on and you continually add, add, add without necessarily looking at the cost.

I think some of the things that Clark has talked about, doing a cost analysis and looking at redundancy are great to go along the weight of sort of meeting my needs but not having this unending amount of data that's out there that we would all love to see and have but is really not practical, costs a lot of money, and doesn't really improve the care of the citizens of California, which is our primary goal.

I would just add a couple of thoughts to that part to it because I think you've really gone a long way. I would ask to the cost analysis, a feasibility analysis so that if you're answering a clinical question or if you're asking a clinical question or any kind of question that you want to collect data for so this whole notion of smoking and how that plays out is a feasibility of actually collecting meaningful data on that component as well.

I would also like to suggest that we sort of stick-to-size statutorily as the data elements set so that we don't expand the size, so that when we add on a new element, we take off a new element, an old element; so we find a sort of priority about how many elements we

want to look at in total rather than just an ever-expanding amount of elements.

I think it's this notion that there is a priority that if you study everything in the world, you're never going to get you anything, but if you focus and you have a priority about what elements are the most important, you'll continue to pick those up and if you want to pull in a new element, you say, "Gosh. This is more important. This is more important than something that you were doing," and that should be added on.

That's my approach to this whole process.

DR. ENTHOVEN: Peter?

MR. LEE: I like everything you said except for saying you said, only do a replacement as technology gets better. It's not adding one thing new. It doesn't have the same cost of adding the prior one. So just saying that it should be only one if you drop one, to me, doesn't seem really to make sense. Cost and feasibility do.

DR. SPURLOCK: I think I would just disagree a little bit on notion of cost because there is an information cost. The notion that you can just collect more information and have it be useful, I think, is the thing that's not measurable. As a physician, I know that all of the test results of my patients sometimes confuse me, and it's just the amass of data have this huge information cost to it; so if we had a focused amount of data, we could have more -- and I

don't have a problem with enlarging the data set over time, but to adding new elements to it time after time after time, gradually getting bigger and bigger, without a thought that there is an information cost, I think, is a mistake and we will end up harming people by data overload.

MR. KERR: We are were hoping that in the cost benefit analysis, the vigilist towards redundancy and so on, to avoid that type of thing. I'm a little concerned when there is going to be a data set to just this. It might actually go to this, or it might go to this, but it would have to based on value.

MR. SCHLAEGEL: Constantly reviewing.

MR. LEE: I think the cost of the cost of the review which may shrink or enlarge the data set, but that concept is --

DR. ENTHOVEN: Bruce, could I just describe is the scenario on which I hope and think we do agree. Today we are unable to California to do a risk adjusted outcome for mortality for bypass graft surgery, and we have a low-volume hospitals that need to have that brought to their attention.

In New York, they were able to do a wonderful study, Mark Chassen, et al, and as I recall it ran 3 or 4 years. Consulting the literature, pilot studies, and so forth, they identified the data elements that they would need, add it to the UB82, four, cabbage, injection fraction was one, I forget what the other ones

were but various medical parameters, probably emergency admission, et cetera, and there's a whole literature on that, as you know.

These are the data elements. Now, we are -- OSHPD advised by it's Blue Ribbon body -- we're going to do a three-year study on risk adjusted mortality, four in cabbage, and so hospitals can then be required for the upcoming three years to record for those cases, those data elements, then they go through this whole thing.

As happened in New York, you've got a wonderful accumulative continuous quality of proven process. Then at the end of at that time, they say, "Okay, great. We've done that study," and your concern is that you don't want those data elements to stay in forever. We address the problem, then society can look at these high, bad outcomes, we hope they depressed and everything else, and the low-volume hospitals shut down or whatever happens, and then we move on to another one.

DR. SPURLOCK: I agree. I think the notion is that if we have a focus on a clinical problem, solve it and then move on is what really after on this whole because there are infinite clinical problems out there. There is just not enough time to do everything.

MR. KARPF: I don't necessarily agree with that. The slippage is backwards. The possibility for slippage is backwards is quite substantial. I think that once you start gathering data, the biggest piece is

sort of putting the systems together, and once you start gathering data, getting centinel data out of that, it becomesa lot cheaper.

DR. SPURLOCK: Michael, one of the things that Clark said that I think underlies that what we didn't talk about is this notion of sampling. If you wanted to do a sampling method, you don't have to use continuou data to accomplish what Alain wants and what I want, which is information on motality out of cabbage. You don't need every piece of cabbage data out there to get something some of that. You may need a big sample. It's a sampling process.

MR. KARPF: What I don't want to do is get into a position where we study a topic, we have an answer, and then we leave that topic and don't come back to revisit it because that won't be very effective.

DR. ENTHOVEN: You might say we found that those hospitals that are operating in volumes below the recommended, like 200 or 300, we're going to carry the study on you for a while; although, in fact, it's hard to do a risk adjusted outcome study unless you include them all in this state, I suppose.

MR. KARPF: The study in Pennsylvania showed dramatic effects on the increase on mortality, it showed a clustering of procedures in high-tensity institutions.

DR. SPURLOCK: I think the concept is all services research is written large, and it's a research

project with a beginning and end that's got a well-defined process that you sample, you do whatever it takes to do, and that's how you do it.

DR. ENTHOVEN: Okay. I think we have a consensus. Will anybody object if I just say by consensus we agree on No. 2, formerly 3 -- 4?

MR. KERR: No. It's No. 4. We can add a new 3. There's a couple of concepts here. The first one is that we're not looking just at information at the health plan level, but also at the medical group level and the hospital level, and these are already actually already being done so we're just being redundant here, but if possible, and if and when possible, we would like to information done in the ambulatory surgical level and the nursing home level, if and when's that's feasible; so of expand the areas where people are actually seeking care.

The second idea there --

MS. BOWNE: Excuse me. Are you willing to add the "if and when feasible"?

MR. KERR: Yes,

DR. ENTHOVEN: Well, Clark, how does that different from encounter, lab, pharmacy, and x-ray data that's in the computer now?

MR. KARPF: Well, we're talking about inpatient and outpatient here.

MR. KERR: Right.

MR. KARPF: Both systems are set up to pay

for the large database zone. When you get into the outpatient arena, most places aren't computer based at that point in time.

DR. ENTHOVEN: Oh, encountered data. That's from the doctor's office, they've got the hospital records.

MR. ROMERO: Right, even in the doctor's office, there are certain things that will come off of billing records that you could track. You can track immunizations. You can do audits but --

MS. BOWNE: Shockingly, you can't always track immunizations. There's been a big problem for the health plans in reporting their HETUS data, and that's why I said "if and when possible." Some physician encounter data is physician visit and whatever the physician did isn't separated by that.

DR. KARPF: But you can drive towards documentation as long as you keep it confined to something that's reasonable and possible.

DR. ENTHOVEN: But doesn't encounter data lab, x-ray, pharmacy -- isn't that going to include what happens in the ambulatory center where there's an encounter in the nursing home?

MR. KARPF: That may if you're in a large organization where is has a lot of computer support and it emerges, but if you're in a 4-man group or 5-man group, and you're working off of a paper record, it's a whole different world.

MR. KERR: And we agree that this may take electronic medical records, and it happens. But that's why we say "if and when."

MS. BOWNE: But it's the concept of where you're headed.

MR. KERR: Right. Exactly.

DR. ENTHOVEN: Continue, Mark. I mean Clark.

MR. KERR: Stanford gets ahead and they just lose it. The second concept is that the information be presented at the area that people seek service from. In other words, right now most of the information, PBG's and so, is limited to sort of California-wide. That doesn't tell you -- for instance, if we're her in Sacramento, it might be interesting to know how Kaiser, Health Net, or whatever, how their performance was in your local area where you're choosing as opposed to California-wide; so when, if and when feasible, we like to give people information that's most useful to them. Those are the two.

DR. ENTHOVEN: This is revised 3. So would you change the wording?

MR. KERR: We are going to be a little clear on the lines of what we're saying. Again, we did not modify it since our last time, but these are the concepts.

DR. SPURLOCK: I have a very quick comment on this one. And that's just to piggyback on it with

what's been going on with the data summit. Excuse my conflict of interest here, but, you know, we worked together on all of this stuff and I think we want the same things and when the data summit is not meeting that need, the state should step in. I think Clark said that earlier, and I think that he's absolutely right.

MR. KERR: It's good to have two groups working together on the same wavelength and pushing the same thing.

DR. NORTHWAY: As long as you're throwing things into this, Mike threw in things like home health services, which is different than nursing homes and ambulatory care centers. Home health is the big thing now.

DR. ENTHOVEN: A really good thing about this securities exchange model is the regulatory agency that people talk about and admire is that there is a lot of their saying to the industry, "Here's a problem. Go fix it. If you don't fix it, we'll do it for you." So in of the element in here, you're saying DOC is there. We hope and trust because you guys can do it. If it has to done, we'll do it for you. Is this kind of what you're saying? Peter?

MR. LEE: Just a comment that I think I'll hold over to discuss when we talk about consumer involvement information. What isn't talked about here in the other recommendations really is dissemination. This is about collecting the quality information --

DR. ENTHOVEN: Right. That's the other paper.

MR. LEE: Exactly, but I think it's important that acknowledge that -- well, this says "and disseminated." This doesn't get into the who and how of disseminated, some of the same issues raised about there are dissemination projects currently happening. The state may have a role in that, so we need to recognize the relation of collection to dissemination, which we will be talking about.

DR. ENTHOVEN: Right. That's how I try, between these groups, to define and emphasis to the consumer information people there's an enormous problem which is there is an awful lot of information that's there, somewhere, that people don't know about. It's a huge problem of just transporting existing information, and that's what they're supposed to do while Clark is developing the new information.

MS. SEVERONI: But hopefully Clark has enough consumers involved with that development so that it will make sense.

DR. ENTHOVEN: We're all right then on new item 3?

MS. DECKER: Time check. 35 minutes.

DR. ENTHOVEN: The next one: study and report key information publicly.

MR. KERR: Ronnie is going to take about this one. I just wanted to point out also that these

are really examples that we've given you here.

MR. KARPF: I have to leave; although, Ronnie hasn't made his comments, so I would just like to reenforce once again, I'm very much for this. We just have to make sure that what we mandate is, in fact, practical at this point in time.

MS. BOWNE: Were you taking this a mandate?

MR. KARPF: I was taking the principle as a mandate, start developing key information that it would get disseminated probably. But there are things here that would be very interesting, I think as Bruce pointed out, it's probably impossible to find out who's really done a smoking cessation in their office, and other things on the list would be very interesting, or blood pressure control in the ambulatory setting, it's going to be very hard to be able to document who's really done a good job at lowering blood pressure.

MR. KERR: These are things to work towards.

DR. ENTHOVEN: The wording somehow needs to indicate just that, Clark, that it's important goals because we don't know how to do a lot of this.

MS. HORHAUS: Could we say "pilot studies"?

MR. KERR: Yes, we are going to put that in.

DR. ENTHOVEN: Should it be in the body of

the paper or up front?

MS. BOWNE: That's my concern. If it's pilot studies, that's one thing, but for a group that's supposed to be slightly market oriented, we're getting pretty darn micro managing here.

DR. ENTHOVEN: Rodgers?

MR. RODGERS: It seems like you all have dissected already. So that in the interest of time so we get to Maryann -- really what the intent here was to basically say and suggest that we look relative to the plan level and then down to the medical group and IPA level, and I'm not going with the details here, what we've had, experientially at the hospital, for example, with cabbage and what have you, is to basically look and from a perspective of things in which we have a fairly significant dearth of information from perspective and performance, basically see if we can get our hands around that, look at that in context of health plans, look at what happens in medical groups and IPA, really at those two levels.

The problem with moving further down when you start to look at individuals, it's hard to look at a provider from institution to institution because things vary from institution to institution that go may impact that individual provider's performance that is not controlled by that provider.

So it's really an effort to not at all be prescriptive but certainly suggestive that we clearly

have some areas of things that we need to look at, and the context of what is the beginning of really trying to put something out there. More broadly for the public to look at comparatively, this is a reasonable place to start, and at two levels. If we look at if from the health plan level and different data, medical group, possibly IPA level, and then data possibly at the hospital level; so that's where we need to head.

DR. ENTHOVEN: Rodney, could you just comment on the idea of, say, this is kind of like rationale for these earlier data requests and whether to put that as a recommendation as opposed to at the body of the paper, reasons why we ought to be doing this?

MR. KERR: I think we saw these as potential pilot studies that could be done. Again, it is pilot studies and two examples of those pilot studies. This is not a mandate we're talking about.

DR. ENTHOVEN: Okay. Examples.

Spurlock?

DR. SPURLOCK: I actually like a lot of these, but I don't want to critique each one of them individually. I think it's a principle that we're looking at, and the principle is the drill down information, where we call it drill down in the world, where you get down to the level that's really important to that individual person; so I think it was accomplished a lot in number 4 and so if we wanted to say more specifically "drill down" and to do public

health type issues as a second thing, you know, as a priority, I certainly can adopt that, and then we don't have to critique each one of these things and say, "This pilot study is more important than that pilot study. The group can decide which pilot study makes the most sense.

DR. ENTHOVEN: Yeah. Barbara?

MS. DECKER: I guess I'm concerned that the way this is literally worded, and I realize you all are going to revise it, but a lot of this stuff, I think, is already being done, and this says under private contract employment, "the state would contract," I think is the way it was said. You should remember the statement that was made earlier on about only addressing things not already being addressed, or something like that, and actually say it in this, because I look at it and I see 4 or 5 that are already being done on other forums.

DR. ENTHOVEN: So many of which are underway?

MR. LEE: Specific studies should be undertaken by the list of some of the major of purchasers, the stateholder groups, or the states under contract.

DR. WERDEGAR: I like that and don't exclude the state from being able to do these things.

DR. ENTHOVEN: So words about pilot studies, examples, when they're feasible, important.

Okay. The former No. 6 becomes No. 5, "ensure basic safety standards for patient care."

MR. KERR: Let me explain that. The issue is the basic concept of medicine refers to no harm, and we think there's an opportunity to really make a major improvement in safety for the public. And the idea being it's not novel in almost in every other area, the FAA has a certain minimum requirements for flying. We even for gasoline have 87 is the minimum you can pump, but there is no such thing in terms of actual performance in terms of safety issues for the public. We've seen all of the various information about adverse events that occurred to people. We've seen the data in California as well as other states that indicate big differences in risk adjusted surgical mortality issues, and so on.

The basic concept here was that a Blue Ribbon group of, again, providers, consumers, purchases, would establish what are areas that are important to protect the public safety? We gave a couple of examples. We talked in terms of adverse surgical outcomes but this group would decide exactly what that would be. It would essentially decide what are levels that we consider safe for the public? They would start with setting some standards in those areas. They would determine a time frame in which providers would have to meet these, you know, these requirements. Then they would decide also that who's going to enforce them? Is

it going to be an issue of accreditation by an existing organization like JCHO or some other group, or would it be a question of state licensure that would decide those issues?

The goal would be to raise that performance bar over time because right now we're concerned about the fact that there is a wide variety of variation, not only in the treatments that are given, but in terms of adverse events and in terms of terrible outcomes for some people, depending on the institution. What we're trying to say is we will start to work on the concept of giving the state of California, the people of California, the basic safety for that when you go in to be treated for medical health regardless of where you go in the state, you'll be guaranteed a certain level of safety, which is not the case now.

It's a new concept, but one that has been implied in almost every other non-health industry.

MR. ROMERO: Clark, would an example of this be for a given procedure the mortality rate must be kept below some level? I'm just trying to understood of how it works.

MR. KERR: Let me give you an example. This is a bad example. It's heart attacks because this is something that is not elective so it's a terrible example, but if it were gastrointestinal surgery or something a little more elective case that would be the case. Let me use heart surgery. We'll pretend it was

an elective thing.

In California what we found is in groups that do 200 more of treating heart attacks, risk adjusted by random, UCLA. The average in the state is around 13 or 13 and a half percent mortality. It ranges from 6 or 7 percent to about 17 or 18 percent of that group.

MS. DECKER: Medical management or pharmacy?

MR. KERR: No, this is the risk adjusted mortality.

MS. DECKER: Of what?

MR. KERR: For heart attack.

MR. KERR: It various among those institutions to do 200 or more between about 6 to 7 and 17 to 18 percent morality, the average of around 13. If you go down to a level of those institutions that are treating 50 or more, the variation goes up to about 28 percent mortality; so the idea might be -- and this is just purely fictional -- but the idea might be "Okay. If the 200 and above, the maximum one, goes to 17 or 18, maybe we ought to establish a standard of, say, 20 percent." That would eliminate none of those that are larger volumes but would protect against -- and this is a bad example because it's not elective, but let's say it was some other surgery that's elective, that those that are at 28 percent would have to get their act together in a couple of years or else they couldn't do

that procedure.

Essentially it's guaranteeing the public that you will not have that high level, and then year after year in consultation with experts, this rate would go down and try to improve the safety and performance of systems based on performance of outcomes.

MS. BOWNE: I'm not sure if this is just to keep us awake or not, but I've been an hospital administrator and I've seen we're having rampant mortality at the hospital. I'd like to suggest a couple things about this. For one, I think that much of this is privileged information through the quality assurance processes, and while unquestionably we would like to have better basic safety standards for patient care, I do not envision this at all. It's not really a managed care issue. It's a basic, you know, whether you're managed or unmanaged. It's a basic issue. I don't think it's within the purview of this Task Force. I think they're complicating issues on the legal access to this data with a quality assurance, and I would also like to suggest to you quite strongly, if using your example, that were the case, one would say then close down the privileges for heart surgery for that hospital but not necessarily close down that hospital, which is what you're narrative seems to indicate.

MR. KERR: No. No. It would be just that service. If you couldn't pump 87 octane health care in that specific are, you would not pump it out.

MS. BOWNE: I guess what I'm saying is that although well intentioned, I find this not within our mandate and too broadly drawn.

DR. ENTHOVEN: I want to put myself on the list, but go ahead.

DR. SPURLOCK: I just want to make a couple of quick comments on this one. There's a little bit of language between what's here and what Clark said, and I think the key issue with this one would be the enforcement component issue of it. And I'd kind of like to have a lap discussion about the regulatory organization, whether this should be part of OSHO or should be outside of OSHO. I'm really confused about that. The enforcement obviously is the critical piece to all of this for any standard. I like the idea, Clark, and you said that there could be other agencies, other accrediting agencies, that could do this kind of factor, and I would like to see that in print.

The other aspect I have to say is that I have to have a little bit of perspective of whether this is going on at all because the joint commission, NCQA, AAAC, and other agencies are looking at this. There is a flaw, and I think there maybe not the kind of issues that you have centered on for importance, but the folks that look at the accrediting agencies and have worked with how do you set standards and how do you do that, have developed a forum, a lot of issue, and there is a reasonable insurance that the citizens of California can

go to most places and get a reasonable amount of care.

I don't think we can't improve and part of the reason that in the medical care area and quality, we got rid of quality assurance because we recognize that you can't assure quality, you can only continually improve it; and so we don't use the word "quality assurance" anymore. We talk about how do we continually improve, and I think so that's the thrust of what you're getting at; so I can buy into that. I just needed to sort of see on paper that this whole accreditation issue needs to be more complete.

MR. KERR: We will certainly add the accreditation part of that, but the concept is through guarantee of the public, a certain safety board that would improve health.

MS. BOWNE: But that's what your licensure does.

MR. KERR: I don't think so. I think licensure talks about processes. I'm not aware of licensure actually going in and saying, "This is your max. This is the max that we'll accept; so this is the max that we'll accept in terms of these services." I don't believe that exists. This is a different concept.

DR. ENTHOVEN: Dr. Alpert?

DR. ALPERT: Licensure doesn't do that. It establishes a minimum standard, as Marjorie said, about which somebody would be admitted to practice medicine in this case.

DR. SPURLOCK: Accreditation is a higher level.

DR. ALPERT: And then it simply responds to the adverse events. Now, it can have, if the board or the agency is pro active and wants to do things and help the public, it might decide to publish a brochure here, there, or something like that.

For the most part, I'm just saying that licensure doesn't ensure this. I think this is a good concept, but I agree with a lot of premises that it might be difficult to do. There are going to be geographic variations. Within one city you ought to maybe have a certain standard, but the rural community is 500 miles way. There's some problems with it, but conceptually it's a good idea.

MR. KERR: I think that would be a good start, but I'm not sure that we have, you know, 87 octane in Sacramento, but as you go outside the hospitality, it goes down to 83. So cars are cars and people are people, so it eventually should be a basis to that.

DR. ENTHOVEN: Spurlock and then Schlaegel.

DR. SPURLOCK: Don't get hung up on the outcome process because if you think about other issues that are very important, probably with heart attacks the most issue is the process issue. What's the time when from when they hit the door to the time they get

thrombolytic. In clinical medicine that's probably more important, and that's not an outcome. That's a process issues. I think accrediting that is a higher level than licensure. I think it does do more, and if people knew that, we would be able to improve. We would get that information back and continually improve so we could lower that number because that is clearly connected to outcomes. It's a lot harder to measure outcomes. It takes a lot more people, and that process surrogates and it's much easier to deal with; so don't lose that in the whole thinking.

DR. ENTHOVEN: Bruce, you reminded me of an episode that happened some years ago. When HCFA came out with their mortality and AMI in California, the list of statistically significantly better-than-average hospitals was still the Kaiser Foundation hospitals, and all the entities get to write in their comments and usually they are why we screwed by this process.

Kaiser people rather generously pointed out just what you're saying, that AMI, the critical thing is how fast not only door to needle, but onset to needle and time, and we are located in urban areas where most of our members live pretty close and can get to us, and it's rather unfair to the rural hospitals or at least you need to recognize that, that in the case of rural hospitals --

MR. KERR: This would be part of the risk adjustment that you're going into. Also, I think that

AMI is a poor example of that situation.

DR. SPURLOCK: It's quantitatively the most important.

DR. ENTHOVEN: Clark, I guess I have trouble with the regulatory aspect it this. I don't know whether risk adjustment can bear the weight of shutting down a hospital as opposed to --

MS. DECKER: It's not shutting the hospital.

MR. KERR: I see it as a real incentive --

MS. BOWNE: Please correct it to state that. That is not what it says.

DR. ENTHOVEN: Right.

MR. LEE: It's an easy amendment. It's "patient activity in that specific area of practice," which I'm sure would be taken immediately in a friendly amendment.

DR. ENTHOVEN: Where is that?

MR. LEE: That is in the last paragraph. It says, "in the medical group," et cetera, et cetera. It's "patient activity in that specific area of practice should be appropriate and curtailed." that could be misinterpreted to mean "patient activity in all areas should be curtailed"; so if you do poorly here, it ripples through the institution, and I think that is absolutely not the intent.

DR. WERDEGAR: There is jurisdictional problem with Department of Health Services, frankly, in

analyzing this language, which looks at the quality of care and hospitals and emergencies rooms, nursing homes. I think to have this paragraph indicate the importance of collecting this information for continuous quality improvement, when you get into the realm of sanctions or closing, saying the service can't be done, I'm not sure that OSHO or the commission wants to do this. They really would have to figure out what does the Department of Health Services do when -- because they have a lot to say whether a hospital stays open or closes or what portion of a hospital can function. I'm not sure that we -- recommendations can be made, but I think this would have to be talked through a little bit more. We can get into the old business of quality standards haven't been met and the hospital has to be closed.

MR. SCHLAEGEL: I was going to say the same thing. Let's stop short of saying we'll collect the data and get not into the club aspect of this thing of we're going to close it down.

DR. ENTHOVEN: Carol Horhaus?

MS. HORHAUS: Can I just suggest consideration in addition to what Peter had said in that sentence: "If the medical group, hospital, or other relevant health care organizations cannot meet basic standards of patient safety, then positive improvement action should be applied. If improvement action fails, then patient activity in that specific area of practice should be appropriately curtailed."

Does that add a bit more?

MS. DECKER: We just did that.

DR. WERDEGAR: Well, I just thinking you're taking on new functions for this new commission that are currently of the functions of the Department of Health Services and you'd want to think that through.

MR. SCHLAEGEL: How about everything but the last sentence will be used? And then "curtailment" would be left to the other --

DR. ENTHOVEN: We just take out the "curtailment" sentence? Is that what you are saying? Is that a friendly amendment? Is there an objection to that?

MR. KERR: I'd like to hear the description.

DR. ENTHOVEN: Well, Clark, one of the things we learned from Demi was one of his principles to drive out fear. One of the very delicate problems here is how to get people to honestly report mistakes, and to do that you have to have a tremendous effort to convince them that they're not going to be punished or retaliated against.

The airline pilots of management do this because for the environment -- we know you're an excellent pilot. We know you don't let it die. If a mistake happened, it was because the system was wrong, not because you're a bad pilot. So they report, "Gee, I pulled the wrong lever," and then the reaction is --

MS. O'SULLIVAN: These aren't mistakes. These are like patterns over a long period of time.

DR. ENTHOVEN: Well, some of them are not mistakes, they're infection rates. It's just a matter of some concern just to bring the heavy hand of regulation. What you get is coverups, evasion. There's so many opportunities to create a culture in which the data aren't reported.

MR. KERR: Well, an alternative is to go the FAA route, which is essentially you set standards. You do measure it. You do evaluate. The state comes in and there are quality improvement programs to put in place, but there's not a curtailing, everything up to, except curtailing, so that there is pressure try and meet safety standards. You won't be kicked out of business, but people know. They'll be talking to you, and you'll have programs to try and improve your proponents, and so on. I just hate something this important to continue to be ingored, as it is now.

DR. RODRIGUEZ-TRIAS: My question was: Is it? Because what I hear is that there are already these various agencies with the regulatory functions, which includes, I think, the State Health Department, and I'm asking would the task of this new agency be very similar to what we said in terms of the previous area in regulation, to look at what is being done and to try to coordinate it and fill in the loopholes, strenghten the existing regulatory infrastructure, if you will, and

activities because what I see is it's almost like taking on an impossible task. I mean to set the database for it but then to get some kind of agreement as to which are the triggering numbers of corrective action.

MR. KERR: It would be new for health care. It's not new for most other industries. The reason I guess I'm concerned is having to talk to Letian Leap, who's a leader at Hartford who has done the studies in the United States. He has told me personally that he thinks that the situation is getting worse, not better in the United States; so I worry about all these things we have in place not working.

If you look at the Lance article that came out in February of this year, they indicate that the problem may be twice as bad as what he found in the 80's, and if you look at some of the long-term trends that we've had, and they're limited, that the state has had, we don't see necessarily the improvements we'd like to see in terms of risk adjusted outcomes versus certain things we're looking at.

I'm just afraid unless we do some sort of intervention, the current situation will continue on, and we need to do something to improve it, and this is a concrete way to do it.

DR. SPURLOCK: That ignores what they just went through at their Richmond and Martinez facilities. I mean they could close down those things. You didn't have to have any of those adverse events in there; so

the big hammer is there for quality. I mean it's not absent, it's just that you want to re-tweak it, and I think we all want to do the same thing.

MR. SCHLAEGEL: Clark, I'm just concerned. The other day at the Health Services -- we looked at this whole notion of why don't you just close down all the cabbage, the facilities that are doing a number of cabbages, et cetera, and I finally had to ask my question: Well, why would a physician want to go and do an operation in a facility that has a bad record? And the answer was for economics. That new surgeon coming out of school could get long-term privileges at the other facilities, so giving back to this unintended consequences of some of our actions, if we want choice in loss for light, or something, for individuals to start closing down facilities for these are the only places these folks can have procedures, I'm not sure how I want to vote on this

MS. BOWNE: Speaking of which, why don't we call for the vote?

MS. O'SULLIVAN: Didn't we say five times we weren't closing down facilitities and that ten times I've heard people saying "closing down facilities"?

DR. ENTHOVEN: Not facilities, just specific programs, in the specific practiced area.

MS. SEVERONI: It's just so very different. I mean I'm confused about where I am here on this, but I have to say that it is appealing to me

because the public has been asking over and over and over again now for somewhere where we can -- they can know, we can know, that that facility that you're talking about is at the level that it's at; so I really don't want to have my heart operation there. Too bad that that's somebody coming out of med school and needs a place of practice. I don't want to have my heart surgery there for crying out load.

DR. ENTHOVEN: We have this elaborate mechanism with JOTCO and everything else, and they're not working.

MS. O'SULLIVAN: Don't you believe we have big various of outcomes?

DR. ENTHOVEN: Yeah.

MS. O'SULLIVAN: And so doesn't that just go straight to the heart of that? At least if we can't fix these variations and outcomes, people can know that they exist and make decisions based on those, and that actually would fix the variations, letting the market work.

MR. KERR: The other thing we talked about was not set any standards hole, simply to make the information public, but we realize that politically that is almost impossible to accomplish. We tried this type of thing. So the issue is if people prefer to keep the information private, but just you had to meet a standard or do you want to have everybody know your dirty laundry, and that's choice. Either one would work, but

you can't have none.

MR. LEE: I've heard two major complaints about this idea, and first, there is attention between quality and first and in some cases is there a role for curtailing choice because the quality dangers are so severe. The thing that I pretty much disagree with is, one, of probably managed care specific, which I think is reasonable but for most consumers, health care is managed care so we have attention there, and I think that managed care is one of the healthiest things that is driving the industry, so to speak, in a better qualification way to look at quality. So I'm concerned about saying let's not deal with this when the vast majority of consumers are in managed care.

The other is who does this and what's the back end? I mean I've suggested the amendment as to rather than say this is an OSHO function is that the state should -- would the appropriate regulatory entities look at a way to do this and put the right mechanisms in place to evaluate so that we don't get into a turf issue to who's the right entity to do it, but to address the appropriate entities either solely or in conjunction should look at this sort of process.

DR. WERDEGAR: I think Lee sort has it.

DR. ENTHOVEN: I'd offer just one other of those -- I was going to make the same point and whatever suggestion Peter would be setting deadlines for that decision to be made just to the hold the industry

statement by 5 years? 3 years and whatnot?

MR. LEE: I think it's a 3-year time frame for something like this is very reasonable.

DR. ENTHOVEN: I'm having a very hard time calling a vote because it's a little unclear what we would be voting on. I wonder if we could just agree that Clark would --

MR. KERR: I've got the sense of getting rid of "curtail," the sense that it not be necessarily OSHO -- we're talking about the time frame.

UNIDENTIFIED SPEAKER: Or "so, so."

MS. O'SULLIVAN: I don't want to be on the Task Force that names the agency "so, so."

DR. ENTHOVEN: So this is resolved by saying that go Clark will work on this and Shapiro and Peter Lee and are going to craft a new draft.

MR. KERR: If you've got ideas, please help us.

DR. ENTHOVEN: And anybody else, please fax Clark by Monday morning. We are working on one terrible schedule because something like December 2nd these have to be recycled and back out; so if you want to make yourr inputs, they've got to come very quickly.

There was a grand deal here. Maryann talked about making the market work and I promised her we're going to do vulnerable populations so we've allocated her 45 minutes.

So here we want to start with Tony and

Helen as the authors, and then Maryann has faxed us a proposed set of amendments. So we'll start with the paper, fairly briefly, then we will talk about the recommendations, 1 and 2, and then we will review Maryann's recommended additions.

DR. ENTHOVEN: All right. Tony?

MR. RODGERS: Just to start out, and we do have some modifications that I'd like for Helen to kind of summarize to the modifications that I've into our report, but if you look at the vulnerable populations and you remember yesterday we were looking at the survey, that if you listed the people's survey, they would fall under some -- for those who had problems that had preexisting conditions or conditions and many of them were in the vulnerable population group, as we defined them.

Why I think that is important is that as we look at the issues that have percolated so much of the frustration on the part of the consumers and other individuals, advocates, it focuses around how managed care handles the vulnerable populations within their membership and the degree of flexible, the degree of compassion they show, et cetera. So taking that as kind of a general driver of why this is important for us to deal with -- and maybe I'm stating the obvious -- I'd like to talk a little bit about of what I see are the issues as we develop this report.

There are market issues that we have been

discussing, issues related to choice, the availability of choice to vulnerable populations, and we'll define that. There are, of course, dissatisfaction issues centering around access to specialists, hospital centers of excellence, as well as the delivery of care, how care is delivered in a compassionate way. There are customer recruitment issues; that is, there is -- some people call it "skimming," "redlining," or "disincentives" that are created for managed care organizations to enroll or to aggressively market to vulnerable populations and that also reduces choice. Then there's a differentiation of products and of service models for the vulnerable populations. Even the market issues, why isn't the market addressing these issues is the question, and what can we do to stimulate that?

And finally, the other side of the issue is policy issues. One of the policy issues is that there isn't consistent compliance to existing standards related to how people should be serve, and that may be addressed -- and I'm going to talk about the revetory responsibility, but when you listen to the populations of vulnerable, they complain about their disputes not being resolved in a timely fashion or their remedies not being appropriate to what they're requesting, and that's a policy issue in how we can address those. Those aren't really addressed for the market.

Then there's issues of customer protection for quality assurance that we can assure a basic level

of quality to people who have unique needs, et cetera. The level of consumer involvement in the processes of care as well as in the policy processes as to how policies are set were within health care.

And then finally for those who venture forth and do good things, the plans that move the bench mark higher, what is their protection in the market that they won't be adversely selected or priced out of the market because they are doing the right thing? Whereas, those plans that aren't doing the right thing, who stay in the market because of cost, that they can offer relatively inexpensive products because they aren't investing in information technology and all those other things? How can you protect those plans that do the right thing, so to speak, and those medical groups that do the right thing?

So a couple of things. We know that the vulnerable population has a higher propensity to complain about the inadequacies of the system and they are kind of the canaries in the mind. If you're listening to them, you're probably picking up on some of the system problems. Quality leadership principles, for some reason, are not being applied to this market. This is, in other markets you look at what are the quality indicators, and then you evaluate how far or how close you are to meeting that quality so that people can differentiate your product. For some reason, some of those quality leadership principles are breaking down.

And then finally, the consumers themselves are not able to differentiate because of lack of information or knowledge, et cetera, about what's going on with their care or differentiate their choices. So that's a backdrop of our paper.

In our paper, what we tried to do first was define who the vulnerable populations. One of the things you'll notice immediately is many of these populations actually receive -- are a part of governmental purchaser populations. In other words, many of the populations that we have listed here including the elderly, the disabled, disabled children, high-risk pregnant woman, has noted the program that they either participated in or can participate in; so a great portion of this population is in governmental programs.

However, it is not all the population. There are many of these vulnerable populations also in the commercial market and the commercial plans as well, and Helen will talk about adding to this list the mentally ill. We also covered in this -- in our paper, a kind of a summary of the kind of things we were hearing from the testimony and that certainly reinforced in the survey, are the kind of issues that vulnerable populations within managed care seem to have with the managed care processes. Under treatment, restrictions for seeking specialist, lack of expanded systems of care that limit their benefit package or their access to

expanded benefits, discontinuity of treatment; that is, they seem to go from one treatment modality to the other and there's not the continuity between the treatment modalities, length of time for authorizations, lack of customer understanding of how to access certain care. We've added one more, the provider's failure to accurately diagnosis individuals who are vulnerable, et cetera, because either provider's lack of ability to diagnose, et cetera, but that has been a complaint.

We have also looked at the issue of those other vulnerable populations outside of managed care that managed care is impacting because of the way it's driving the market, and those are the uninsured, uncompensated, what is going to happen with the uninsured, uncompensated in the market as those -- as Medi-Cal, Medicare, and other programs that would have been sponsored by government, and government would have been a financer, and allowed the health care delivery system to shift some of the cost as those programs begin to become consolidated, as the fore-profit organizations in the market increasing amount of market share away from the traditional and safety net providers, what's going to happen to the uninsureds? So we addressed that with one of our recommendations.

We also have included on page 6 of our report kind of a summary of guidelines and recommendation that withdraw from merit, many different other reports, but kind of lists out what we think

should be the best practice standards or mechanisms to achieve the best practice standards for this particular population; and so we've listed them there. They may duplicate other reports, but we wanted to make sure that those principles and recommendations were included at some place in the overall report, the Task Force report.

So with that as a background, I'd like to go quickly to our recommendations, and then I need to have Helen talk about some of the modifications she would like to make. Basically what we're saying in recommendation 1 is that the first step in improving the process of due care, the quality of care, for vulnerable populations is that at least for the state and federal or governmental sponsor purchased service, that only those plans that can demonstrate that they're able to identify, track, and report performance outcomes for these vulnerable populations should have contracts, and this will stimulate the plans. Many of them already have this capability, but it will stimulate the plans to assure that they have this in order to compete.

This is to create, if you will, a bench mark or a bar, under which other plans that don't have that capability would not be able to participate in serving this population; and that the state of California would drive the quality of care standards and process for managed care through its contractual relationships by leveraging not only government sponsored, but employee -- the state as employee

purchasers, health care purchaser -- to assure that quality of care standards are embedded in contracts and requirements; and that the Task Force should strongly encourage other purchasers to require the appropriate identification of tracking and reporting of vulnerable populations.

Now, I guess when we were talking about this, we thought maybe that was too limp, as you would say. It was really wasn't doing enough. But when you think about it, nothing else can be done until you can identify the population. Until you can identify within your membership who is vulnerable, you can't really do the quality reporting, the satisfaction report, all those other activities that we talked about today; so this is a step that we need to push the industry to be able to do, especially as it relates to government programs and where the state is a purchaser, so that in general is recommendation No. 1. YOu can read the rest of it.

MS. BOWNE: Can I ask a question about that? Tony, I applaud where you're coming from and where you're headed to. My only caution would be this performance outcome at least, to my knowledge, is not highly developed. You know, certainly all plans should be able to identify, track, do satisfaction surveys, what have you. I guess I would be concerned that where are these peoples going to go if the plans can't do outcomes, I mean, until they can do outcomes?

While I applaud where you're coming from and where you're headed to, I don't want to create a catch-22, where all of a sudden, let's fact it, the vulnerable population is not exactly what everyone is working to sweep in, and I would just caution that are we setting the bar so high that nobody reaches it, and therefore you're hurting rather than helping the system?

MR. RODGERS: Let me ask you this questioning in terms of how the industry would respond to a requirement to report performance outcomes through a contract. They'd either say, "We won't do it for the money you're paying; so increase him out of money so we can make the investment to do that," or they have already made the investment or are making the investment and would be able to respond at a price that the state would accept; in other words, if there's not a stimuli, if you keep putting it off, if you don't say, "The bar is now set here, guys," and then negotiate on price to achieve that level, then you'll never -- we'll always have the excuse, "There's not enough money to make the investment," but we'll price it below what is really going to cost to do this.

Now, I agree that through some kind of special transition dollars or whatever, the state may have to consider that, but this needs to be done or else nothing else works because you lose your members, you lose a vulnerable population and your membership and you only pick them up anecdotally. You don't pick them up

pro actively, and therefore you can't create the pro-active consumer input, the case management process --

MS. BOWNE: The only piece of it I'm questioning is I'm not sure that the outcomes capability in technology and state of the art is there. Now, I presume that by coming up with this recommendation, you're seeking to push it further by having this in place. I'm concerned you're going to go off the cliff, that's it's not in place, that this is not an attractive population to begin with; and if I might suggest, you might want to say on the part on just applied to report performance outcomes, "as soon as technologically feasible," or something like that because I don't want you to create something that's well intended that has the opposite effect.

DR. RODRIGUEZ-TRIAS: Well, it's not as though there's nothing out there, Rebecca. I think that's important. We plan to incorporate what appears as page 6, I believe, which is this table in the recommendations because it makes it much clearer.

MS. BOWNE: I think this should be up in the body, not in the background.

DR. RODRIGUEZ-TRIAS: Exactly. That's what I'm saying. We're moving this up as part of the body because it specifices the recommendations somewhat more to a greater degree; but if you look in the second column, which is quality, the first thing is the "plans

to identify and track" because that's really important. You have to have the straining tools up front; otherwise, you don't even know that that --

MS. BOWNE: I agree.

DR. RODRIGUEZ-TRIAS: The second, "service is consistent with recognized clinical guidelines and community standards germane to specific medical quality and access," and that's really the core of it, to say, "credentialed certified medical groups and providers on their knowledge, sensitivities, skills, and cultural competence that serve vulnerable populations"; in other words, there are already some outcomes, standards, -- desired outcomes, grids, if you will, or protocols or schemata.

One of the very important things about working with vulnerable populations is to recognize the importance that they have had in guiding their own care. I mean if everybody we interviewed with from people involved with multiple sclerosis to people involved with post-polio, and so on, have taught us -- and we know historically that is so -- have taught us about developing the standards; so it's the incorporation of the plans of the people affected in developing and advancig those standards, which is very important, the outcomes.

DR. ENTHOVEN: May I call on me? I fully support your goals, and I think you've done a great job and you really put your finger on an important

foundation for moving forward. I'm worried about the care of the state aspect here. I think if a health plan, one in San Mateo, has a monopoly, if you say you contract only with them and they say, "Well, sorry, but we can't do it," they're going to go fire the health plan in San Mateo. That's too heavy-handed. I like the PBGH approach in which they would hold X percent of the premium.

Les, is 2 percent or 3 percent or?

MR. SCHLAEGEL: 2.

DR. ENTHOVEN: 2 percent of premium is a big part of bottom line, and they negotiate to say, "We will pay you that at the end on a sliding scale relative to your performance of these objectives," and I gather that really gets their attention. You might even say in this case that money could can be used as bonuses for doctors and managers; otherwise, I think this kind of like a death sentence which you know you won't carry on.

MR. SCHLAEGEL: Just a clarification. Is it a question of the technology to be able to get data or is that the outcome measures are not already developed, or it a little bit of both?

MS. BOWNE: I was thinking that the outcome measure has not been developed yet, and while this would obviously encourage them to do it, I don't think you would quite want to create this cliff that you're not going to contract with anybody who says they can't because for a wide variety of reasons, they may be

your best people that you want your vulnerable populations with.

MR. ROMERO: And if I can just say, if there were instances where a government procures from a vendor who over time develops an effective monopoly and the government becomes hostage to it, so a sliding-scale percentage of your premium is a way of creating an incentive.

DR. ENTHOVEN: Les can brief you on the PBGH approach. I gather it's getting results.

MR. RODGERS: One of the things I noticed, because we contract with seven plans, a couple of them are in this room with us, and they have the systems to do this. They don't have the economic reason to apply it across the board. They apply it to tracking asthmatics, tracking diabetics, because they have a management incentive to control the cost of those individuals. They really don't have an incentive for some broader-based tracking, but they have the technology in place.

Now, I'm suggesting that it is not as big a quantum leap to track because the way you do it is you do it through the initial assessment, you identify the issues, and then they become part of a database that you monitor over time. The technology is there. The problem again is either we have to do it by investment of somebody outside has to come in and make the investment or we have to do it by incentives. I like

the idea of a withhold. I think that is a great incentive. It allows people to play in the market, but we do have to move them up to that bar, and we really at some point in this industry have to say below a certain level, you can't participate in these populations because it does put those populations at risk.

MS. O'SULLIVAN: Wouldn't this help us too if the Task Force, instead of encouraging purchasers to do the same thing, encouraging the legislature to require other purchases to do the same thing, so the burden of setting up these systems doesn't just fall on people serving the most low-income votes, but it falls on everybody who's got vulnerable populations in their plans?

MR. SCHLAEGEL: I read it as everybody who has a vulnerable population plan.

MS. O'SULLIVAN: Right. Except we have this restrictive language about plans contracting with the state, and then very permissive language.

DR. RODRIGUEZ-TRIAS: That's why the state is the purchaser actually because we did not see a handle on the other that wasn't some wide heavy-handler.

MS. O'SULLIVAN: But Tony's 7 plans, for example, if the state makes them set it up for everybody, it's going to be nothing for them to set it up for the Medi-Cal population; right?

MR. RODGERS: There's a cost of collecting the data. There's no doubt about that, but the

technology is there to analyze the data, compile it, and to report it. It's the question of the physicians and the provider groups rolling their data up so that you can do that, that an assessment is done so that you can identify that the person falls within certain categories, and then creating the pro-active systems to monitor their care over time. That's what you need, and we're very close actually.

MR. SCHLAEGEL: Tony, are you talking about a different subset of HETUS from the HETUS measures?

MR. WILLIAMS: A lot of the HETUS measures are processed measures. They are not really outcome measures, and I don't want to be prescript about what is significant in particular vulnerable populations. I do know that the physicians in their quality assurance effort have come a long way. We need to roll some of that up, that we have from the delivery systems that have invested. I think we need to use our centers of excellence tp help us design appropriate performance outcome measures. But HETUS is certainly there and everybody is starting to look at that, but it's mostly process, not outcome.

DR. RODRIGUEZ-TRIAS: I think again referring to what we submitted to you on No. 4 on the quality -- No. 5. "Plans to work with vulnerable populations to adopt a bill upon existing quality methodology, QRA guidelines and indicators, like quality

of life and function." I think that's really the operative thinking here, that that is something that needs to be done and needs to be developed.

MR. SCHLAEGEL: My concern is I'd love to have outcome data on my folks, all of them; so I'm wondering if really the recommendation from this group is for managed care and everything else. We need to start pumping some money into research, into outcome measures. I guess at what I'm getting at and not saying all this but why are we limiting it to this group? I'd like to see how measures on everybody in managed care.

MS. SINGER: Mr. Lee?

MR. LEE: One of the things that I think we need to acknowledge at the very beginning, before we get to the recommendations -- while the recommendations here talk about vulnerable populations, issues of vulnerable populations tracked throughout all of our recommendation and in many ways issues of vulnerable populations ripple through non-vulnerable populations. I think it's a very important introduction. I think we've dealt with in some places in integrating issues that touch on vulnerable populations and other papers and not well in some places.

Here, just a couple of suggestions in terms of recommendation 1 is I like the form of using some other sections of having A's, B's, and C's in terms of breaking out the pieces, and I've heard a couple. One is, and I think it would probably be a friendly

amendment, to address Rebecca's point of the technical feasibility. Even though we want to push the envelope, there is a point of what's not feasible. We shouldn't have an impossible bar in terms of the "contract only with."

The second one, which I think is also friendly, is adding on the "incentivizing" is whether it's with withholds or not.

The third point is in terms of the M word on mandate that Maryann mentioned is instead of potentialy with the "mandate" of where we are right now at the second underline is "the Task Force strongly encourages the state as purchaser to collaborate with other large purchasers to set common standards with regard to incentivizing, identification tracking, reporting performance outcomes," et cetera; and so again, we're doing a lot of work here in trying to have common standards across different purchases and that would be a way to try to sort of push the state to try to work with PBGH and say, "Let's incentive the same sorts of things, the same quality of standards."

MS. RODRIGUEZ-TRIAS: Peter, are you suggesting then the amendment is to instead of "require," to "incentivize"?

MR. LEE: Yeah. They're separate issues. Really I'm saying something separate. My suggestion is, A, is your current state your first underline, is the state should only contract with those. I agree with

that. As a separate recommendation, I think the state should, as purchaser, because we can make different sorts of recommendations to the state than we can as some private actors, should incentivize potentially with withholders, as are being done in the private sector, better performance in serving vulnerable populations.

The third is the "Task Force recommend the state as purchaser collaborate with other large purchasers to require and have common tracking, identification, reporting on performance outcomes for vulnerable populations."

MS. SINGER: Are we ready to take a straw vote on recommendation No. 1? Those in favor of recommendation No. 1 as adjusted? I guess we can move on to recommendation No. 2 now.

MR. LEE: Before we move to 2, one of the things -- you did a number of allusions to the grid, and many of the elements in the grid are very good. Some of the pieces are reflected in other papers and some aren't; so there's this cross-referencing that says this is over here, when it's not over there right now. I think it would be useful to look at, for example -- maybe I should way until we get to that point.

I take these, the grid, as recommendations and you're recommendations, as I understand it --

DR. RODRIGUEZ-TRIAS: That's what we're doing. We're moving it upward.

MR. LEE: This is one of the things we're

voting on. The Task Force is voting on these recommendations on the grid as well. Is that the intent of your working group?

MR. RODGERS: Yeah. We were trying to figure out how we could avoid putting things on our paper that other people would be making recommendations, and that there might be some, you know, some problems with that so, yeah, we can do that.

MS. BOWNE: And just to the extent that they were changed in the papers, I think they should be changed on the grid so that it ties together, and I think there are some tweaks.

MR. LEE: Or potentially by persons. There are certain areas here on the grid that maybe we didn't talk about it when we did an issue and have already talked about, I mean -- I'm sorry. Maybe we should deal with recommendation 2 and then get to the grid and see --

MS. O'SULLIVAN: Can I just ask a question on 1? When we talked about the state using its purchasing power and working with other groups like, PBGH, are we talking about the state as PERS purchaser also? That would be a good thing, I think.

DR. ENTHOVEN: Sure.

MS. O'SULLIVAN: Then we could say that the state, using off of its purchasers?

DR. ENTHOVEN: Okay.

MS. SINGH: Recommendation No. 2.

MR. RODGERS: Recommendation No. 2 resolves around the issue of what happens to the uninsured, the other vulnerable population that's in the non-managed care environment and the effect that managed care has on reducing access for that population just by the nature of the way that we have reimbursed in the past safety net hospitals through medical and now that's changing. So we made a recommendation that the state should earmark -- and that wasn't my word. We had a lot of discussion about earmarking -- an allocated portion of the billions -- we also had a thing about "billions" --

MR. LEE: As opposed to "billions and billions"?

MR. RODGERS: Right. -- of our cost avoided attributable to the Medi-Cal selective contract in the area of CalPERZ, managed care to begin expansion of coverage for Californians uninsured.

This was where we would see getting the financing to provide coverage, and when you think of coverage, we're talking about putting them into this managed care platform in some kind of way to the other uninsured, and the thought that we put here is: Okay. You can identify the money, let's say, and you can make the allocation. Should you create a statewide program? And the problem with is that is the uninsured problem is different in different places or segments in geographical areas of each state.

The problem with the uninsured in Los Angeles County is different than the problem of uninsured in San Joaquin or Solano, et cetera. How do you create a program that doesn't continually leave gaps? Well, we thought the best thing to do was that the counties have begun to look at this issue. L.A. County is doing that. Now that it's decided to have a 600-bed hospital instead of a 750-bed hospital, look at what their role will be in the future. San Bernardino, Riverside, Contra Cost County, all the counties are beginning to look at what they do now as a delivery of care to move these populations into some way of managing their care.

What we're proposing is that any dollars would be used to incentivize counties to restructure themselves working with the private sector, private-public partnerships, whatever, to serve this population or to find creative ways to cover the gaps in coverage. So that was the direction we would go.

MR. ROMERO: Tony, can I ask you a clarifying question about your intent? The state recently has taken advantage of federal subsidies for insuring previously uninsured children, those whose income is above Medi-Cal qualifications but who can't afford insurance. Would you consider that to be sort of eligiblility from this recycling?

MR. WILLIAMS: No. This would be the groups that are not covered by state or federal programs that

still remain -- where the federal government has come in and brought money to create a program, we're not talking about that. That should go through the normal purchasing plan.

MR. ROMERO: I'm sorry. I wasn't clear by your question. I don't know the proportions, but it's jointly funded. I think it's like a dollar a state to $3 fed, something that that. My question was about the state portion. Should the state get credit for those dollars?

MR. WILLIAMS: For the county dollars too? I'm not --

MS. O'SULLIVAN: I would hope these would be additional dollars.

DR. RODRIGUEZ-TRIAS: Yes. The fund would be additional because that is an important population, but I think we're talking about what? About a million, less than a million? 600,000, and we're talking about 7 million uninsured in the state so it's part of it.

MR. SHAPIRO: Let me counsel against picking your financial source, as opposed to telling the legislature or governor to fund it because let's say we get a windfall of it back with tax or let's say we get a windfall where the Congress augments the kids programs, and also I'm not sure who's going to oppose the CalPERS saving. You're identifying a particular pot here, and I think you're constraining the options that might be available to this populace so I would give, by of

examples, to things where there's new that not going to go to a savings or others, but I would give yourself more options for the uninsureds.

MS. RODRIGUEZ-TRIAS: Do you want to give us language in this?

MR. SHAPIRO: I'm going to open up a discussion.

DR. ENTHOVEN: It wasn't intended to be restrictive, was it? Just an idea to the state, saying, "Look, you are saving billions of dollars on managed care and if there's problems being created by it, why don't you recycle some of those savings?"

MR. SHAPIRO: When I see those dollar signs, we all have priorities on what to do with those savings, including the governor, and I'm just saying that there maybe other option as well. I'm not saying you should exclude this, but I wouldn't limit yourselves to it.

MR. RODGERS: Can I point something out in terms of dynamics that go on in the local level and that are causing major trauma at the local level that caused boards of supervisors to start shutting down their county hospitals? It is an open checkbook for every uninsured person to say go to the county, and you see what is happening is that managed care has brought some groups in, it has left some groups out, and the way to shift your cost is to make you're employ uninsured so they just use the county system.

The boards are getting very nervous -- board supervisors, et cetera, at local levels are getting very nervous about that. The state has to come in and give to local level some ability to control their financial destiny in this area.

MR. SHAPIRO: I fully agree. I'm just saying keep your options open.

MR. RODGERS: I agree with you. I do agree with that, and we will rewrite that. I guess my other question is do we agree that other than federal or large -- like the Children's Health Initiative and whether those populations role in for the remaining populations of uninsure to incentivize counties to come up with creative ways to cover those populations, like L.A. County is doing.

DR. ENTHOVEN: Dr. Northway?

DR. NORTHWAY: Yeah. I've got a little bit of a problem giving away money that we save in a program that we're not really sure yet that's actually worked in the Medi-Cal managed care, and I can tell you there are a lot of counties around, Olympic programs and other mainstream programs, that have such low rates that it's almost impossible for us to get people to participate in this. So before we give away the savings on this program, let's make sure that the funding level for these state --

DR. ENTHOVEN: This is not talking about Medicaid managed care. This is talking about the

California Medical Assistance Commission publishes a report each year which boosts about the huge amounts of money it saved through selective provider contracting. For last year it was between 1.1 and 1.5 billion, which we'll round to say $1.3 billion; so that's got nothing to do with the moving of people into prepaid plans.

DR. NORTHWAY: Well, it is to a certain extent because they took money out of C-MAX budget and put it into the managed care budge; so I think it is, Alain, to a certain extent that they shoved those dollars over to either to the Olympics or to the mainstream programs, and those came out of C-MAX so we are talking about savings, I think, that were done in this new way to manage this population. I'm just saying before we start to move that money to fund another population, let's take sure that the funding is adequate for the population that falls under the managed care program. I think Tony would probably not be opposed to that.

MR. WILLIAMS: I would not be opposed to that.

DR. ENTHOVEN: Any other comments on recommendation 2?

Without objection, we'll consider that. We'll rework the wording on the lines we discussed. Okay. Now we have Maryann O'Sullivan, who sent us on November 19th a memorandum.

MS. O'SULLIVAN: Do we want to discuss

No. 3 since that's become a recommendation? I have a couple comments under it. You have a new recommendation to No. 3 now?

MS. RODRIGUEZ-TRIAS: No. No. This is not a new recommendation. This is really part of 1.

MS. O'SULLIVAN: So am I correct in understanding that you mean that as a recommendation?

DR. RODRIGUEZ-TRIAS: Yes. This is sort of a more graphical, if you will, or better organized way of putting the components of recommendation 1, which is the tracking and quality.

MS. O'SULLIVAN: Before we get to the extra recommendation, I just have a couple of comments. Just little things that I think are just friendly amendments. Under quality No. 5, we talk about quality of life judgments. And friends in the disability community make the important observation that those judgments -- judgments of how quality of life is should be made by disabled people even with those conditions, that those of us who are able-bodied from the outside apparently judge quality of life to be less than what people who have the disabilities judge it to be. So if we can just get some language in there.

MR. RODGERS: What we were trying to do and we saw it in the survey, people say that somehow the health plan, the health system, made the quality of their life worse because they didn't address something, and somehow we have to say if you are going to take

responsibility for a membership, you have to monitor the quality -- if that person was able to work and they this should under -- the conditions of care going back to work, why weren't they able to --

MS. O'SULLIVAN: I see. Okay.

DR. RODRIGUEZ-TRIAS: Maryann, maybe it might allay some of the anxiety. We have made an over-arching principle, this involvement of the effected people in determining outcomes so that applies there as well. Tony's points was illustrated by that letter that I shared with you of the man who has post-polio syndrome and could not get a wheelchair because his plan said, well, he could walk some, but he needed a wheelchair in order to go shopping and do other things because he couldn't walk for very long.

MS. O'SULLIVAN: Okay. Because it came up also in terms of under benefits No. 4, that the creating -- looking at the definition of medical necessity, again, that these vulnerable populations be included in that decision-making process, but maybe you've got it in more over-arching -- I also was looking for that same thing at the top of page 4 --

MR. RODGERS: You want to change to 4 to? I'm sorry. Which one?

MS. O'SULLIVAN: 4, benefits No. 4, as devising a definition or discussions of medical necessities that vulnerable populations be included in that process.

DR. RODRIGUEZ-TRIAS: I'll going to put it on top in bold.

MS. O'SULLIVAN: Good, because it came up again on page 4 at the top, you've got that nice list of things, steps to, so that's another good place for it.

DR. ENTHOVEN: Let me just clarify. There are things in here on page 6 in this table that are not in the No. 1 that we reviewed.

DR. RODRIGUEZ-TRIAS: We moved it up front. We moved all of this as subset of No. 1.

DR. ENTHOVEN: And did the Task Force all look at that item by item?

MR. LEE: That's what MaryanN has started to talk about.

DR. ENTHOVEN: I see. Okay.

MR. LEE: That's what I noted when you were out of the room. There's needs to be cross-referencing. Some of these parentheticals note "see recommendation X" and recommendation X in another place doesn't reflect what's here exactly, and we need to make sure those are happening.

DR. RODRIGUEZ-TRIAS: And they're happening to the newest version.

DR. ENTHOVEN: We have something here. Let's see. "The governor and legislature to direct the state's health plan agencies to insure that at least three of the five standard referenced coverage contracts meet the extended benefit and accelerated authorization

needs of chronically ill."

MR. RODGERS: Where are you reading?

DR. RODRIGUEZ-TRIAS: Benefits No. 2.

DR. ENTHOVEN: I would just say that's a large know large expansion, and in some sense a distortion of the intent of the standardization. That's taking the standardization exercise and really bending it a long way to what people didn't have in mind when they did the standardization. I'm almost concerned if we have such a small group here with none of the health plan people, we're a little out of balance.

MR. ROMERO: Mr. Chairman, can I make a procedural here because I want to direct this to the authors particularly. What if -- two things, first of all. Any surviving recommendations out of the grid ultimately need to be put in the same format as the others so that that the rest of the world sees them as in the exact, summary and you agree with that. How would you feel about excising out of the recommendations anything that isn't primary about vulnerable populations or restricting it just so it cross-references so you have the papers; you're not trying to recharacterize a recommendation being made in another paper, it no small part because we will be delivering these simultaneously and it may be very difficult to make sure that we get them harmonized.

DR. RODRIGUEZ-TRIAS: It would make it easier for us actually because we don't have to

cross-reference to the latest, exact version, and I think if we use Peter's suggestions that in the introduction we say that many other papers address the needs of vulnerable populations that will probably occur.

MS. O'SULLIVAN: Just to be careful because if you would go through and just take out anything that's a cross-reference, you're going to lose something, like, for example, the one that Alain just raised goes beyond -- there's a whole thing in there being sure that the benefits meet the expanded needs of vulnerable population, and that's isn't addressed anywhere else so I just caution against, you know, don't by mistake under benefits No. 2 just drop that because it says it's in the standardization report, because it's not in the standardization report.

DR. NORTHWAY: The same with access No. 2. That access No. 2, I want to make sure it applies to all children, not just the children who happen to have disabilities or that are in foster care. It's the whole issue that Harry Christy brought up is this the child technically have a chronic illness, had a tumor, and they weren't able to get the right access. So I would not want to see two taken out unless -- and I absolutely wouldn't be opposed to this -- if all children were brought into the vulnerable population.

MR. LEE: I think that one way, as it's late in the day and, Alain, I understand your concern,

that if some of these are substantially changing recommendations that people don't have an opportunity to have -- it wasn't quite clear to me. I thought there was not enough here until I understood that the grid was part of the recommendation; so I think that's helpful, but I think other Task Force members may not have been clear. I would be concerned about saying, "If hasn't been incorporated someplace else, let's take it out here," rather I want to make sure the whole Task Force understand here's a proposal that might require a change in, for example, the standard reference packages that wasn't brought before the whole group when we considered standard reference packages and is this reasonable? And, Alain, you can say on substance you think that's going to far and say, "Well, how about 2? Okay. 2," or whatever, in terms of this process, but I think that we should flag the issues should be brought up in other papers and then this can serve a cross-reference piece.

MS. O'SULLIVAN: It's interesting. It's a problem with process because really vulnerable populations, we should have had discussion of or -- another way we could have a discussion of that, those populations, and have a representative on the Task Force through each of these papers because they're relative.

MS. SINGER: I just want to make people aware that there are 20 recommendations on this piece of paper. The standardization paper was the one that we adopted yesterday; so our intention is not to go back to

revisit that. We have a substantial number of papers to adopt when we come back in December. To begin to try to discuss all 20 of these, you all know how much time it takes to do one; so I think if we about another process for this I think --

MR. RODGERS: We were trying to figure out a way to communicate within different ERG's, the impact that the ERG's role, whatever they came up with the recommendations might have on the form -- was at the time to embed a sensitivity to the issues of vulnerability without being on every ERG Task Force, and we came up with a matrix to kind of say, "Okay. At a level of detail, I've got to think about" -- when you're thinking of standard contracts, you've got to think about what vulnerable quote, unquote, "populations" will view because they're the ones that are more sensitive about what is or is not in the contract because they can -- when they're a customer, at the point of selection, they're a customer. At the point they see a physician, they're a patient; and at the customer point they are not sure what they're going to get once they become a patient, and we're trying to improve that knowledge base. So we wanted to have something in standard contract that helped, the language was earlier or whatever. Tell me how we can make sure that there's a sensitivity activity to those other recommendations.

DR. ENTHOVEN: Couldn't you have at least said one of the standard reference contracts? You have

to grab the whole thing?

MR. LEE: Alain, that's is an easy thing to -- I think Sara has raised another question. Do we not even deal with these? I think that we need to deal with some of the them in an efficient way, and many of the pieces here, of the 20, are incorporated in other places and we have a recommendation that purchases and just payments for quality. That's one of our recommendations; so many of these are 20 referenced elsewhere. I think the point of how do we deal with ones that are not addressed elsewhere efficiently, we need to address.

I'm concerned about saying that in the time clench we have, we just don't address them. I'm concerned about that, but it I think it might be helpful between now and Tuesday that someone can go through these and say, "This is addressed. This is addressed." We already think we closed the doors on this. Have we or did we not recognize we missed the boat. This issue should have been considered. It wasn't. Here's an amendment. Alain, you say, "One should as opposed to 3," et cetera. That would be a way that I suggest we deal with the grid.

DR. ENTHOVEN: How about we go through and those things like purchases sample that risk adjustment. We take that off of here?

MR. LEE: We don't take it off. We vote.

DR. ENTHOVEN: And those that are new

should go up front where people would understand that there -- like you just hijacked -- pardon the expression -- standardization. I'm glad you didn't make them all five, I mean, because I just think that --

MS. SINGER: There 12 additional recommendations.

MR. RODGERS: Can I give you on that? What our concern was, if you only had an accelerated authorization process and one level of plan, you're limiting choice. We're trying to -- these are the kind of policy issues that we grapple with because if you say there's going five reference plans, but four of them don't deal with this issue of speciality access to a specialist and accelerated referrals, you're telling the normal population basically you can go to the comprehensive place because that's the one that has that mechanism in place.

Now, this is a process issue, to me, because I think we want to do -- I think we all want to do something in this area. I'm not sure how we want to do it. Do we do it back in the plans, or do we put it here and reference it and say, "What we're doing with standard contract, you need to consider this as well"? I don't know.

DR. ENTHOVEN: We have this problem that we've got these papers in the bank, and we're scared to death about reopening them again.

MS. SINGER: What we were trying to do

when Amy though about this grid was by it this way was including it in the recommendations. It would provide your group with the flexibility to say, "What is the right thing to do with respect to the vulnerable populations"? but it wouldn't require the Task Force to making a recommendation on each thing.

MS. O'SULLIVAN: But the problem is that we haven't had anything that's -- either so things are recommendation, it doesn't exist in the Task Force world.

DR. RODRIGUEZ-TRIAS: That's right. That's what we realized after we looked at it and said, "Well, wait a minute. There's some very specific things here."

MR. PEREZ: I see a lot of things on this list that are crucial to my feeling comfortable with the final report that we put out. And if the recommendations that makes sense for specific other -- to be included with specific other ERG's aren't done there, they really get lost. I understand that we've gone over many of these things, but the problem with the process that we're faced with is that we were only allowed to have ERG's of two people. When you limit yourself with the exception of the one I served on -- when you limit yourself to two people on ERG's, then you limit the reports because you only have two points of view and the fact that you have done this great work to address these issues that should have been

included in other reports, means that we really need to just figure out a way to procedurally append them to the appropriate place in the reports that they're actually referencing, and I don't think it means that we truly have to reopen or reconsider things that we've agreed to, but figure out some procedural way to agree to them and put them in the proper context of the reports that they best fit in.

DR. RODRIGUEZ-TRIAS: May I make a suggestion and see if people are satisfied with that? If we come back and on Tuesday and we have incorporated the new elements, that is what isn't someplace else as recommendations, would the group be willing to then discuss it?

DR. ENTHOVEN: I'll put them up front?

DR. RODRIGUEZ-TRIAS: Yeah. If we put them in the 1-A, B, C group.

DR. ENTHOVEN: And then the grid becomes -- we're pointing out to interested people that all through the Task Force, there are things for --

MS. BOWNE: Are we also saying that where we have adopted these in other and you're cross-referencing them, that they will be reflected as they were amended and approved in the other paper?

DR. RODRIGUEZ-TRIAS: Those that have been because we haven't done all the other papers.

MS. BOWNE: In other words, so that we don't refight all those battles? If we've already

passed them, but we've modified the language before it -- you know, and you guys haven't reflected it quite how it got adopted this that this grid would reflect the adopted language from the other papers?

MR. LEE: No. What I suggest that if we just use the one example, which is the most dramatic one, are some that we haven't talked about yet. We haven't talked about formulas yet so we can see what's going to come out. We're going to flag here the issues that are in here, that we've not yet talked about, they're easy. We will talk about them when we get to them. The one flag on benefits 2 is that -- benefits No. 2 is "should some number of the standard reference coverage packages include this or not?" I don't feel it's appropriate so say that issue is done. We cannot talk about that. Rather I'd say we'll have a five-minute discussion to say should it be 1,2, or 3? Vote on that. Then it changes the full thing that comes back or the full final, excuse me. And reflect accurately in the matrix.

MS. BOWNE: Well, I was looking down at benefits No. 5. I think, if I remember my thinking correctly during in all this scrambled eggs of time, that what we determined there was not extended period of time, but I think we came up with some language there about duration of illness or duration of pregnancy or whatever.

DR. RODRIGUEZ-TRIAS: Sure. That all

happened today or yesterday.

MS. O'SULLIVAN: That's not adopted yet. This is better language. We don't have to be confined by the straw vote earlier.

MR. LEE: I think that discussion is a good example of where the discussion specifically talked about the concern of all vulnerable populations. It didn't even hit the radar in terms of the reference packages. That's a good example. We did talk about it. This is where I would say that I would conform with what the final vote is here.

DR. ENTHOVEN: I point to the policy procedural benefits and suddenly I saw this standard contract idea. Here it's a whole different idea and maybe on it's merits if we put it up in front and said, well, beyond what we recognized or recommended before, in addition, you know, we recommended some number of these contracts have these features.

MS. DECKER: I'd like to timekeep. We have 15 minutes left, and we spent 48 minutes on this paper. 5

DR. ENTHOVEN: Okay. Maryann?

DR. RODRIGUEZ-TRIAS: Just one comment before we go to Maryann. What we recommend is that the common denominator in vulnerable populations was that they presented, you know, the challenge to the system because they're requirements are not your average requirements. That's just what it boils down to. These

are people who are in either intensity of care or in mixed up services or in ancillary services that you need to have in place of them are different from what other people need; so that's where the uniqueness comes in and that's why you have to underline that certain paper.

MS. BOWNE: And, Helen, I'm just picking up on just that point under "protections, No. 2. What did you have in mind "but ensure enrollees understanding of coverage, membership rights, and benefits? What do you have in mind there?

MR. RODGERS: The thought was that the plan needs to have some mechanism to validate that those vulnerable populations understand their benefits, their evidence of coverage. I pick up what we do when we have living wills or when you go to the hospital you can get a living will as to what you want done, et etcetera, and the level of informed consent we provide there and evidence that the member understands the implications of what they're signing. That was the same level we wanted the plans to demonstrate that for these vulnerable populations, they do understand how to access their benefits, what the scope of services are from benefits, what the scope is.

Now, they can do that in many ways through an attestation, through -- there's a lot of ways you can do that. You can do that at the point of enrollment, whatever, but it needs to be done. It can done in a physician's office at some point.

MR. LEE: I think that everything on protection are issues we have not yet talked about because I think that No. 1 should come up when we talk about consumer information, which is coming up, and we can address it there.

MS. O'SULLIVAN: Can I just say it's 10 to 5:00. We're going to do vulnerable populations again next week. I want to move. I have this thing that I'm not going to be here to work with next week. There's a long conversation on this next week; right?

DR. ENTHOVEN: Not long.

MR. LEE: I'd be happy to spend a few minutes with staff and eventually Community Health Services -- sorry. Three of those can't, excuse me. Most of the issues, we just need to make sure they come up and the issues we have not yet talk about. I think there's only two or there.

MS. SINGER: Somebody is going to have to prioritize them because there are -- every other ERG will have to prioritize them. This has been our discussion on vulnerable populations. We have four papers to do on Tuesday and we only have six hours and we have time constraints.

MS. O'SULLIVAN: How do we decide that vulnerable populations gets a one-hour discussion and another one gets two and a half?

MS. SINGER: We prioritize.

MR. PEREZ: Our discussion at this point

should not dictate that vulnerable populations get the shorten end of the stick.

DR. ENTHOVEN: They'll be time for it, but I think we ought to be able to wrap it up in another half hour or something like that.

DR. WERDEGAR: I think Peter Lee's suggestion of formatting it so that everybody can see it as recommendations, and many of them I think will either have it taken care of or will be coming up in some of the other discussions so that we make sure that all of the items that are now somewhat buried in that matrix are just made explicit, and I think we can go through them in a very reasonable way.

MR. LEE: Most of these issues over here are part of recommendations that we'll be taking. In dispute resolution we're talking about use of advocates and external or internal program. Each of these are coming up. I just want to make sure they come up in an explicit way.

DR. ENTHOVEN: We're going to do that Tuesday morning. I'm really going to have to role through it fairly quickly, but I agree that that should be done. I don't know. Maybe people will see three of the five -- at least certainly five of --

MR. LEE: No problem.

MS. O'SULLIVAN: There's a little mistake here just in the -- this is just one recommendation; and so Roman numeral I, then it should be Roman numeral II,

Roman numeral III instead of the other two three's so you're not confused there. All the numbers should be Roman numerals. It's just one recommendation. It's all about a report from the legislature to the Department of Health Services.

Really what this recommendation says is that all of the recommendations that we're making in all the parts of our Task Force report should apply to the Medi-Cal to the extent that the Medi-Cal population isn't already better protected than those recommendations.

Then in the second paragraph it goes on to say that the Department of Health Services should report annually on the status of the impact of Medi-Cal managed care. And then Roman numeral I, II, and III talk about what the report should include. Roman numeral I is saying it should report -- all the bullets under one are in terms of quality and access issues, and what we want is a comparison amongst the plans. In most counties it's between the plans because it's just two plans in a county, and then it can be among counties. Then a comparison of the provider panels amongst the plans. There are some very interesting things we're learning there. We hear about the mean mainstream plans. Now we're look at the provider panels and we're finding out that it's not what you might have thought it was. The providers in the mainstream plan, the so-called mainstream plans, they're not getting their

private providers to come in. They're get a small percentage of the providers in the so-called mainstream plan are actually mainstream providers, that really they're relying on the same providers, what initiative we're relying on, they're safety net providers. Anyway, to look at those. We can tell what's going on.

The third one is to compare quality and access and cost indicators for Medi-Cal population to the insured population to see where do they stand relative to those of us who have private coverage.

The fourth bullet goes to understanding benefits and responsibilities in managed care. So how is the education system working or are Medi-Cal beneficiaries really understanding how to use the system so that they can get adequate access?

The next bullet asks to look at the effectiveness of translated materials. Are they working? It's linked to the one before, and also the capacity of the plans in reality to provide multi-cultural, multi-lingual services.

The next bullet goes to provider continuity and what's going on in terms of provider continuity and asks to look especially at -- Medi-Cal population bounces on and off coverage and what is that doing in terms of continuity.

Finally to look at patterns of default and disenrollment and why are people disenrolling and what's the story there.

MS. DECKER: What's "default" mean?

DR. RODRIGUEZ-TRIAS: Not making an actual choice, but automatically being assigned.

MS. O'SULLIVAN: So the state decides which plan you go into because you didn't fill it out the form.

Then Roman number II asks the report to include an impact statement about the impact of Medi-Cal managed care on the safety net, which we heard about earlier this morning.

Then finally to look at the impact of Medi-Cal managed care on the capacity of the public help health entities. The first one looks at the impact of actual direct services from the public health and safety net providers. The next one looks at traditional, tracking of epidemiological trends, and population-based health education to report on the impact of Medi-Cal managed care on those things, and that's it.

DR. ENTHOVEN: Maryann, what would be your estimate of the number of professional person years that it would take -- this is not a facetious problem. I'm thinking they have limited capacity over there. If they put more money into the bureaucracy that means fewer people covered; so I'm just trying to ask myself, how many people would you need to do these?

MS. O'SULLIVAN: I don't know. That question hasn't been asked on anything else that's bee

proposed, but I don't know the answer. It may not be as bad as you think because a lot -- if you look at the waiver, the DHS got approved by HCFA to be able to do the two-plan model. There are a lot of promises about gathering data and analyzing. A lot of this, they're already supposed to be doing; so what I'm concerned about is it's difficult to get information from DHS, to put it mildly, and this would ensure that that happens.

DR. ENTHOVEN: If a lot of this they're supposed to be doing -- we know they're supposed to be doing A, B, C, and E so we're not asking for extra work. The only extra work we're asking for are that we recommended that they publish the reports that they agreed to do.

MS. O'SULLIVAN: Tony, you know because you have to give a lot of this information to the state.

MR. RODGERS: We do No. 1.

MR. LEE: You said, "No. 1," so you mean the first bullet?

MR. RODGERS: First bullet. We do the second bullet among the commercial and local initiative related to Medi-Cal only. We don't have any information outside of that. Bullet No. 3 we don't have a private insured patients in California. We don't have that information.

MS. O'SULLIVAN: On bullet No. 2, I had an intern do it in three counties this summer.

MS. BOWNE: That was an intern for the

summer?

MS. O'SULLIVAN: No, actually it wasn't. It was a month.

MR. RODGERS: We don't have the private pay, maybe the state does. If that's what you mean between pay?

MS. O'SULLIVAN: Yes, privately insured patients.

MS. BOWNE: The state doesn't need it because they have Medi-Cal.

MR. RODGERS: We don't have that, but we do know our panel and we know the commercial plans for the panel. We can evaluate consumer understanding, et cetera, we're doing that now. Analysis of effective translation, we're doing that now. Analysis of provider continuity --

DR. RODRIGUEZ-TRIAS: Excuse me, Tony. Let me ask you. You're doing this in your program?

MR. RODGERS: Yes.

DR. RODRIGUEZ-TRIAS: Is every Medi-Cal provider is doing that?

MS. O'SULLIVAN: The contracts are all basically the same.

DR. RODRIGUEZ-TRIAS: Okay. So then it is being done. I just wanted to know if it was a unique thing.

MS. BOWNE: Since Kim Belshe is a Task Force member, could we ask some of the Sacramento base

staff to -- because I understand where Maryann is coming from. This would be helpful. It clearly is directing the addressing the mission of this Task Force, but I think what Alain is saying is know how much extra work is it because then that gives us an idea if it's, you know, within a certain realm then we would want it done. If it's in a certain other realm, 10 times or 100 times perhaps not. So if we could have staff get this to Kim Belshe and then, Tony, maybe you could sort of think about it with your folks because I think Maryann is genuinely saying this would be helpful information to have, and certainly if we can encourage and help get that we should be doing if it's within reason.

MS. O'SULLIVAN: I think we just heard that this is all stuff that's happening --

MS. BOWNE: But he's one of the best providers. They're not all like him.

MS. O'SULLIVAN: No. The contracts require it. That's why got the HCFA --

DR. ENTHOVEN: My question wasn't rhetorical. It wasn't to imply this was some huge crux. I'm just trying to explore these criteria. They're supposed to be doing most of this anyway, or what is new work, what is not?

MR. LEE: But the thing that they don't do, which is very important, is that they don't collect any comparatives. They've got most of the data, and it would be worth it to do a comparative. That's very

important work doing done. I think Rebecca's proposal is a great one, but I'm not hearing opposition to this being submitted so when it comes back for a vote, if Kim says, "These two things, boy, those are really big ticket items," then the whole Task Force can say, "Big ticket not worth it, or big ticket worth it." Then you can ask the whole Task Force, "Do some --

MS. O'SULLIVAN: I'm not being facetious when I say this is about making the market place work because it's about telling consumers about what they're choices are worth, which ones are doing better and which ones aren't.

MS. BOWNE: I wasn't saying it in opposition. I was saying it so we can make an informed decision.

MR. RODGERS: She is putting in a system to collect this data within Medi-Cal, but it does not include private insured patients. That's all I'm saying.

DR. ENTHOVEN: Is there a question of tying in Medi-Cal with CCHRI?

MR. RODGERS: I don't know.

DR. ENTHOVEN: I mean where are they on that since we have this ongoing PBGH --

MR. LEE: I would suggest that it's a great additional recommendation and DHS be encouraged to integrate with PCHRI efforts to have comparable data between commercial and Medi-Cal populations. To me that

supplements that, not doing it even as a mandate, but to encourage it to collaborate with CCHRI. Isn't that a friendly amendment, Maryann?

MS. O'SULLIVAN: Yes.

MR. ROMERO: Maryann, also in the spirit of marketing support, is it necessary that this report be prepared annually as opposed to say biannually? I know the market is moving fast.

MS. O'SULLIVAN: Biannually might be fine. I don't know.

MR. SHAPIRO: Can I also add also that you don't have to report to the legislature. You will get to. Have the users who need it -- if this is public, you can bring it to us. This suggests we have to do something with it even if there is not a problem. I don't want everyone that's doing reports to come to us as if we're going to fix it.

MS. O'SULLIVAN: What I don't want lose is that the legislature needs -- someone needs to require --

MR. SHAPIRO: I think it's required that they publish it to do it and then it's public in some fashion.

MS. O'SULLIVAN: Fine.

MR. LEE: So that means the governor or the legislature require that DHS --

MR. SHAPIRO: Right.

DR. RODRIGUEZ-TRIAS: Let me show some

very strong support for No. 3 in the reverse because I think this is key to all the issues of vulnerable populations because the public health entities still provide quite a large segment of the services that they need irrespective of where they're getting their primary care.

DR. ENTHOVEN: My guess is we all think that this is fine, but we'd like to see -- too bad Kim isn't here. We'd like to hear what they do and formulate it in such a way that it sort of clarifies with respect to that issue, like they're supposed to be doing 3 or 4 of things. Where do they stand? Are they doing them?

MS. O'SULLIVAN: So it wouldn't be okay, Alain, is if Kim says we're already doing those. It's getting a retort out that's readable. There's some language in there about readable, understandable, clear. DHS has a lot of information, but it's very difficult to get it.

MR. RODGERS: I agree that the state should publish an annual report because it right now it goes up there, and they don't use it unless the legislature asks them for a retort. I think they should be required to publish an annual.

MR. LEE: I've used some of the reports that come out of DHS. They're very hard to use and pour through report through and they're incredibly difficult.

DR. ENTHOVEN: It's too bad, if we can

just incorporate them in CCHRI that's user friendly

MR. LEE: There's some different issues, though.

DR. ENTHOVEN: Sure. We will revisit this Tuesday morning.

Are there any members of the general public here who want to address the Task Force at this time and are prepared to do so briefly?

MS. DODD: Catherine Dodd of ANA, California. Very briefly. I appreciate those who are still here. Some of us are members of the public are not here by assignment but are here voluntarily observing this so I appreciate the opportunity to address you.

I wanted to say I really support the vulnerable population document as it's written, and I have a question about the service of case management. I want to ask the people who are doing the rewriting on integration, under 3 on, Access and Quality, you talk about plans demonstrating the ability to integrate services. There's a difference between demonstrating and an ability to integrating. You can have a free-standing Smith in a hospital, that doesn't mean theoretically things are integrated, but they're not. I really think the specifics of case management have been documented to provide the continuity of service for those vulnerable populations and I cite organizations like On-lock in the Medi-Cal primary case management for

high-risk pregnancy that has saved California millions of dollars.

I want to probably just end with a joke abut quality. I was encouraged to tell this joke by Clark Kerr: A taxi driver and a priest got to heaven and met St. Peter at the gates and Saint Peter says -- the priest says, "You go first. You go first." So the taxi driver went up to St. Peter and said, "Look. I've been driving taxis in New York for 40 years. I've gotten women to the hospital to deliver their babies, I've escorted senators. And St. Peter said, "That's great. Here's your gold card. You can have access to any of the unlimited one of the clouds, unlimited length of stay. Just head up on it and count them. The priest said, I'm Father Agustus from St. Bernadine's Parish and I implemented Saturday mass and Sunday confession and Saturday confessions and we had community outreach projects and the priest says, "That's nice. Here's your platinum card. You can get to the second level of clouds and you have unlimited stay, but only on that second level of clouds, and Father Agustus said, "Wait a minute. I did Saturday mass, Saturday confession, community outreach." And Saint Peter says, "You don't understand, Father. We're no longer into quality assurance by process. We're into quality assurance by outcomes. " The taxi drive drove. People prayed. He preached. People slept.

And now along those lines, I want to urge

you to support the flexibility part that was presented that we didn't get to comment on in terms of the data collection being able to add those additional data sets, but I also want to urge against limiting how to dismiss a data element whenever you add a data element because we wouldn't be able look retrospectively at what's happened on inpatient basis in managed care if people had been limiting those data elements as we had added others.

A also want to point out that in both home care and long-term care, Medicare reimbursement is going to require collection of minimum data set data on admission and on discharge, and that will be the beginning of our quality data for long-term care; so it is collectable.

While it's not directly plan related, as a member of the public, when I'm choosing a health plan, I not only want to know can I choose a physician, a nurse mid-wife, a chiropractor, I also want to know what the data is on the hospital that you come from. When you talked about quality data, you talked about cardiac surgery. I'm talking about falls. How many patient falls were in that hospital last year? That's a data element that's directly related to the quality of nursing care. There are more injuries related to people falling while they're in the hospital, and that's really important for me when I selecting a health plan for my mother and my grandmother and myself.

thank you for your time.

DR. ENTHOVEN: We have one more person.

MS. MUNOZ: I would like you please listen to Dr. Rodriguez-Trias when she speaks about possibility of overregulating and a great deal of regulation. You've got protocol. You've got hospital accreditation. You've got every individual with it's surgical review board, and you've got Medicare and Medicare tells you not only what you can prescribe, but how wide the hospital door has to be, and that's in a maternity ward.

So the licensing implies regulation. There's nothing in the regulations that says you have to be good at it, but that's done in other ways. The government's duty really to the consumer is to provide a level playing field. It's manifesting unfair to Kaiser to allow people to practice health financing and health maintenancing without delivering the goods that they're promising, without out delivering the full spectrum of care that they're supposed to give or that they implied that they're going to give.

If you allow that unfair competition and by that I mean if you allow them to skimp on nursing care, if you allow them to second-guess doctors that are licensed by the state of California as to what shall be referred, what shall be prescribed, you'll get Gresha's Law, the bad ones will driving out the good.

Thank you.

DR. ENTHOVEN: Just to conclude here. The

name was Stephanie. Tuesday we are going to dispute resolution, consumer information and involvement, medical necessity, integration and woman, and we will spend a brief time on reviewing this exercise on the grid. By looking at putting into the -- I guess Helen will that do -- putting into the text those things that are in the grid that are new as opposed to cross-references.

Thank you very much.

(Whereupon the proceedings were adjourned at 5:15 P.M.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

I, Stacey L. Wishner, CSR 11538, a Certified Shorthand Reporter in and for the State of California, do hereby certify:

That the foregoing proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision; that this transcript is a true record of the testimony given by the witnesses and contains a full, true and correct record of the proceedings which took place at the time and place set forth in the caption thereto as shown by my original stenographic notes.

I further certify I have no interest in the event of the action.

EXECUTED this day of , 1997.

Stacey L. Wishner, CSR